The Government's Expenditure Plans 1996-97 to 1998-99

DEPARTMENT OF HEALTH

DEPARTMENTAL REPORT

This is part of a series of departmental reports (Cm 3202 to 3220) which, accompanied by the document *Public Expenditure: Statistical Analyses* (Cm 3201), present the Government's expenditure plans for 1996–97 to 1998–99.

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The Government's Expenditure Plans 1996-97 to 1998-99

DEPARTMENT OF HEALTH

DEPARTMENTAL REPORT

Presented to Parliament by the Secretary of State for Health and the Chief Secretary to the Treasury by Command of Her Majesty March 1996

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CONTENTS

The purpose of this report is to present to Parliament and to the public a clear and informative account of the expenditure and activities of the Department of Health.
If you would like further information on anything contained in the report, or have any comments or suggestions on its content or presentation, please write to:

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FOREWORD

I am pleased to present this sixth annual report from the Department of Health. It describes the progress and achievements of the past year and sets out expenditure plans for 1996-97 to 1998-99.

The report differs from its predecessors in focussing more sharply on the different business areas for which the Department is responsible, the resources committed to each and the results that are being achieved. Spending plans, performance and priorities for further development are described for each of the Department's business areas: public health, the National Health Service, social care and departmental management.

The measures and progress described in the report demonstrate the Department's continuing commitment to public health. Encouraging progress towards the Health of the Nation targets has been made in 1995-96 and I expect further progress in 1996-97. The child immunisation programme continues to be successful and the incidence of childhood diseases is now at its lowest ever level.

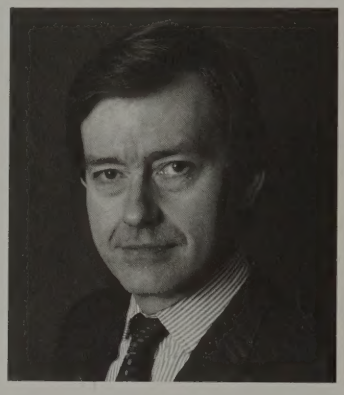
On 1 April, changes to the structure of the NHS will be completed as regional health authorities are abolished and district health authorities and family health service authorities merge to form single new health authorities. The new authorities will have a central role in progressing the priorities we have set for the NHS, for example raising standards in mental health services and improving cost-effectiveness by making better use of clinical research. I also look to them to continue to deliver across the wider NHS agenda. We have already seen great progress for instance in virtually eliminating waits for hospital treatment of more than 18 months. Plans and progress on these fronts are discussed in detail in this report.

Following a period of considerable change, we have the right structure in place to enable the NHS to concentrate on its main purpose of improving health and delivering high quality health care.

Social services departments have continued to develop services to prevent family breakdown and to provide appropriate care, support and protection for children and young people with special needs. Local authorities are developing their community care services to ensure that vulnerable people get the help they need, with more emphasis on helping people in their own homes and encouraging a variety of service providers in the public and independent sectors. From 1 April, all local authorities will have their own community care charters setting out what the public can expect from their local services. In parallel, new local eligibility policies based on a national framework will be in place. These will set out the circumstances in which people can expect the NHS to provide them with continuing health care services.

The health and personal social services have undergone significant change in the last 5 years. This has resulted in improved standards of services, more influence for the users of services and more choice and diversity. A great deal more money has been made available. At the same time, the NHS has achieved substantial efficiency gains. More are planned. We are taking action to streamline NHS management. In the coming year, I shall look to local authority social services departments to look at the efficiency with which they are using their resources. New powers for the Audit Commission and the Department's Social Services Inspectorate to carry out joint reviews will help us to spread best practice more widely.

This report is an important element in our accountability to Parliament and the public. I hope that it will help improve understanding of our policies and of the way in which resources are used.



STEPHEN DORRELL

1 INTRODUCTION

1.1 This is the sixth annual report of the Department of Health, providing financial information about the spending programmes of the Department. The Office of Population Censuses and Surveys (OPCS), which was represented in previous years' reports, will now appear under the Chancellor's Departments following the decision that from 1 April 1996 it should be amalgamated with the Central Statistical Office (CSO) to form the Office for National Statistics (ONS).

Department of Health

1.2 The Department of Health is responsible for health and personal social services in England. The Health programme is funded mainly by central government. The Department sets overall policy on all health issues, including public health matters and health consequences of environmental and food issues. It is also responsible for the provision of health services locally, a function which it discharges through the National Health Service Executive. The NHS Executive is responsible for the central management of health authorities and for holding NHS trusts accountable to Ministers, in particular for the performance of their statutory financial duties.

1.3 The Personal Social Services (PSS) programme consists largely of spending by local authorities. The Department sets the overall policy for delivery of personal social services and provides advice and guidance to local authorities. The programme is financed in part by central government grants and credit approvals, but most local authority PSS revenue expenditure depends on decisions by individual local authorities on how to spend the resources available to them.

Aims and Objectives

1.4 The Department of Health's overall aims are to improve the health and well-being of the people of England and to secure the provision of high quality health and social care for those who need it.

1.5 It pursues these aims by supporting Ministers in developing appropriate policies, and determining the necessary resources for the delivery of services through the NHS and local authorities, so that:

- the health of the nation can be protected, promoted and improved;
- high quality care can be secured through the NHS;
- high quality social care can be secured through local authorities and other agencies; and
- Ministers can properly discharge their statutory responsibilities and accountability to Parliament.

1.6 The allocation of Ministerial responsibilities is shown in **Annex C**. The organisation of the Department of Health and of the NHS is shown at **Annex D** and **Annex E**. Further details about the Department's structure and responsibilities can be found in the Statement of Responsibilities and Accountabilities (Department of Health, 1995)

1.7 Each year the Secretary of State identifies specific key objectives in pursuit of these aims. These objectives are set out in the chapters that follow covering each of the Department's business areas.

Cash Plans

1.8 **Table 1** summarises the cash plans for the Department of Health; further details are given in **Annex A. Table 2** summarises local authority expenditure. Both these sets of figures are discussed in greater detail in the sections which follow.

1.9 Details of spending on health and personal social services programmes in Scotland, Wales and Northern Ireland are published in those departments' departmental reports. A breakdown of total Government expenditure on these programmes within the United Kingdom for current and past years is given in Table 1.2 of the Public Expenditure Statistical Analyses 1996-97 (Cm 3221). **Annex B** to this report summarises recent expenditure trends and future spending plans for the NHS in the United Kingdom.

1.10 This year's Departmental Report reflects the simplification of the Supply Estimates. Additional information previously contained in the Estimates can now be found in this Report; **Annex K** provides further information.

Table 1 Summary Cash Plans

£ million

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 estimated outturn	1996-97 plans	1997-98 plans	1998-99 plans
Department of Health									
Health services									
National Health Service hospital, community health, family health (cash limited) and related services [1] [2]	17,089	19,445	21,350	22,241	23,583	25,112	26,213	24,268	25,426
National Health Service trusts [3]		-24	223	303	590	482	440	393	316
National Health Service family health services (non-cash limited) [1]	4,690	5,219	5,613	5,622	5,624	5,754	5,561	7,805	8,101
Departmental administration	231	297	362	334	327	324	307	294	294
MCA Trading Fund [4]				5		1	1	1	1
Central health and miscellaneous services	316	417	423	446	456	510	526	539	551
Total health services	**22,326**	**25,354**	**27,971**	**28,951**	**30,581**	**32,183**	**33,047**	**33,900**	**34,690**
Other services									
Personal social services	18	25	31	34	32	32	33	33	32
Civil defence	1	1	1	2	1	1	3	3	3
Central government grants to local authorities	31	58	83	654	831	772	629	175	170
Credit approvals	84	106	126	132	140	145	103	103	103
Total Department of Health	**22,461**	**25,544**	**28,213**	**29,773**	**31,585**	**33,134**	**33,815**	**34,213**	**34,998**
Of which:									
Central government's own expenditure	*22,345*	*25,405*	*27,781*	*28,679*	*30,023*	*31,734*	*32,643*	*33,541*	*34,408*
Public corporations (excluding nationalised industries)		*-24*	*223*	*303*	*590*	*482*	*440*	*393*	*316*
Central government support to local authorities	*115*	*164*	*209*	*786*	*972*	*918*	*732*	*278*	*273*

(1) In 1991-92, 1992-93, 1993-94, 1994-95, 1995-96 and 1996-97 provision of £125, £295, £628, £1,009, £1,263 and £1,917 million respectively for drugs prescribed by GP fundholders is included in HCHS current expenditure. However, for other years all provision for FHS drug costs is included in FHS non cash limited provision. This reflects the fact that there is no basis for adjusting previous years' figures because GP fundholders did not exist before 1 April 1991 and for future years decisions on the number of GP fundholders have not yet been taken.

(2) HCHS current expenditure includes that element of trust capital expenditure which they fund from their charges to health care purchasers (£234 million in 1991-92, £363 million in 1992-93 £696 million in 1993-94, £975 million in 1994-95, £1053 million in 1995-96, and provisional figures for 1996-97, 1997-98 and 1998-99.

(3) Figures for forward years are provisional estimates.

(4) Prior to 1993-94 MCA figures are included in departmental administration. MCA figures from 1993-94 reflect the reclassification of expenditure following the move to Trading Fund status.

Table 2 Local Authority Expenditure [1]

£ million

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 plans
Department of Health						
Current spending						
Personal social services [2]	4,216	4,622	4,974	5,660	6,644	7,323
Port health	5	5	5	5	4	4
Total current spending	4,221	4,627	4,979	5,665	6,648	7,327
Capital spending						
Personal social services	147	133	132	118	148	170
Total net capital spending	147	133	132	118	148	170
Of which:						
Gross spending	*174*	*166*	*169*	*187*	*189*	*208*
Capital receipts	*-27*	*-34*	*-38*	*-69*	*-41*	*-38*
Total local authority expenditure	**4,368**	**4,760**	**5,111**	**5,783**	**6,796**	**7,497**

(1) LA PSS expenditure did not form part of the control total until 1993-94, except for the element of central government support within it. This was described in the Statistical Supplement to the 1992 Autumn Statement (Cm 2219).

(2) From 1993-94 includes additional resources for community care reforms.

DEPARTMENT OF HEALTH DEPARTMENTAL REPORT

1996-97 to 1998-99

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CORRECTION

Page 2, Table 1

In 1996-97 the figure for NHS hospital, community health, family health (cash limited) and related services should read 26,208 instead of 26,213; the figure for NHS family health services (non-cash limited) should read 5,570 instead of 5,561; and the figure for Departmental administration should read 303 instead of 307.

2 EXPENDITURE

The Health Programme

2.1 The health programme consists of:

- NHS Hospital and Community Health Services (HCHS), providing all hospital care and a wide range of community services;
- NHS Family Health Services (FHS), providing general medical, dental, pharmaceutical and some ophthalmic services and covering the cost of medicines prescribed by general practitioners (GPs);
- Central Health and Miscellaneous Services (CHMS), providing services which can most effectively be administered centrally, for example welfare foods and support to the voluntary sector; and
- the administrative costs of the Department of Health.

Expenditure Plans

2.2 Spending on the NHS in 1996-97 reflects the priority being given to health. The Government plans to increase its current spending on the NHS in England by £1.3 billion to £31,491 million in 1996-97, equivalent to 1.6 per cent in real terms. Government spending on NHS capital will be £1,563 million in 1996-97 and in addition to public capital receipts from sales of surplus land, the NHS is expected to benefit significantly next year from private sector capital investment under the Private Finance Initiative (PFI). Total NHS capital spending on the NHS in 1996-97 is expected to be some £2 billion or more. In total the Government plans to increase its spending on the NHS to £33,054 million in 1996-97, equivalent to £1,660 per household. This is an increase of 0.6 per cent in real terms over the original plan for 1995-96. Current spending on the hospital and community health services will grow by 1.1 per cent in real terms.

2.3 Full details of outturn and planned expenditure on the National Health Service both in total and for each of its subprogrammes are given in **Table 3**. This shows net expenditure (that is, spending financed by the Exchequer) as well as gross expenditure (that is, including the additional sums available to the health programme from receipts from the sale of surplus land, charges and income from private patients etc). Gross figures for the UK are given in **Annex B** to this report.

2.4 Table 3 reflects the areas in which funds are actually spent. By contrast, Annex A reflects the classification used for technical reasons when funds are voted by Parliament for the NHS. The main differences from Table 3 are that much spending on capital is now financed through trusts' external finance limits (EFLs) and an element of health authorities' payment to trusts for NHS services; and that spending by GP fundholders on drugs is included with HCHS, not FHS. Full details of the adjustments made to the Annex A figures to produce those used in Table 3 are given in the notes to the latter. All NHS figures quoted in the remainder of this Report relate to Table 3.

Table 3 National Health Service, England - By Area of Expenditure

£ million

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 estimated outturn	1996-97 plans	1997-98 plans	1998-99 plans
Central government expenditure National Health Service Hospitals community health, family health (cash limited) and related services Current expenditure [1]									
gross	16,121	18,332	20,117	20,840	21,682	22,665	23,552	24,144	24,691
charges and receipts [2]	-479	-526	-539	-494	-407	-349	-371	-371	-371
Net	15,642	17,806	19,578	20,347	21,275	22,317	23,181	23,773	24,320
percentage real terms change		7.1	5.7	1.0	2.6	2.1	1.1	0.1	0.1
Capital expenditure [3] [4]									
gross	1,576	1,659	1,815	1,783	2,049	2,065	1,853	1,795	1,720
charges and receipts [2]	-178	-169	-115	-213	-208	-259	-310	-300	-290
Net	1,397	1,489	1,700	1,570	1,840	1,806	1,543	1,495	1,430
percentage real terms change		0.3	9.7	-10.3	15.0	-4.5	-16.8	-5.5	-6.5
Total									
gross	17,696	19,991	21,932	22,623	23,731	24,730	25,405	25,939	26,411
charges and receipts [2]	-657	-695	-654	-707	-616	-607	-681	-671	-661
Net	17,039	19,296	21,278	21,916	23,115	24,123	24,724	25,268	25,750
National Health Service family health services (non-cash limited) [5]									
current expenditure									
gross	5,289	5,986	6,558	6,914	7,377	7,768	8,230	8,574	8,887
charges and receipts	-599	-642	-650	-664	-696	-751	-736	-769	-786
net	4,690	5,344	5,908	6,250	6,682	7,017	7,494	7,805	8,101
percentage real terms change		7.2	6.2	2.8	4.9	2.2	3.9	1.6	1.5
Departmental administration									
current expenditure									
gross	278	306	346	334	327	333	314	303	303
charges and receipts	-18	-32	-27	-16	-17	-17	-18	-18	-18
net	260	274	319	318	310	315	295	285	285
capital expenditure									
gross	21	23	43	16	17	8	13	10	9
charges and receipts	0	0	0	0	0	0	0	-1	0
net	21	23	43	16	17	8	13	9	9
Total									
gross	299	329	389	350	344	341	327	313	312
charges and receipts	-18	-32	-27	-16	-17	-17	-19	-19	-19
net	281	297	362	334	327	324	308	294	294
MCA Trading Fund [6]									
current expenditure									
gross				5	0	0	0	0	0
charges and receipts				0	0	0	0	0	0
net				5	0	0	0	0	0
capital expenditure									
gross				0	0	1	1	1	1
charges and receipts				0	0	0	0	0	0
net				0	0	1	1	1	1
Total									
gross				5	0	1	1	1	1
charges and receipts				0	0	0	0	0	0
net				5	0	1	1	1	1
Central health and miscellaneous services									
current expenditure									
gross	362	471	485	505	524	577	599	614	626
charges and receipts	-54	-65	-72	-67	-75	-76	-79	-81	-81
net	309	406	413	438	449	501	520	533	545
capital expenditure									
gross	7	11	10	8	7	8	7	7	7
charges and receipts	0	0	0	0	0	0	0	0	0
net	7	11	10	8	7	8	7	7	7
Total									
gross	369	482	495	512	531	584	605	620	633
charges and receipts	-54	-65	-72	-67	-75	-76	-79	-81	-81
net	316	417	423	446	456	508	527	540	552
Total National Health Service current expenditure [1]									
gross	22,050	25,095	27,506	28,597	29,910	31,342	32,695	33,635	34,507
charges and receipts [2]	-1,150	-1,265	-1,288	-1,240	-1,194	-1,193	-1,204	-1,239	-1,256
net	20,900	23,830	26,218	27,357	28,716	30,149	31,491	32,396	33,251
capital expenditure									
gross	1,604	1,693	1,868	1,807	2,073	2,082	1,873	1,812	1,736
charges and receipts [2]	-178	-169	-115	-213	-208	-259	-310	-301	-290
net	1,426	1,524	1,753	1,594	1,865	1,823	1,563	1,512	1,446
Total									
gross	23,654	26,788	29,374	30,404	31,983	33,424	34,568	35,447	36,243
charges and receipts [2]	-1,328	-1,435	-1,403	-1,454	-1,403	-1,452	-1,514	-1,539	-1,546
net	22,326	25,354	27,971	28,951	30,581	31,972	33,054	33,907	34,697
percentage real terms change		6.9	6.0	0.6	3.7	1.8	0.6	0.1	0.1

(1) Funding for that element of trusts' capital expenditure which they fund from their charges to health care purchasers (£234 million in 1991-92, £363 million in 1992-93, £696 million for 1993-94, £975 million for 1994-95, an estimated £1053 million for 1995-97, and provisional figures in 1996-97, 1997-98 and 1998-99), included within HCHS capital here, is included within HCHS current in Table 1.

(2) From 1991-92, includes trust receipts/charges (For current, £37 million in 1991-92, £82 million in 1992-93, £153 million in 1993-94, £300 million in 1994-95, and an estimated £310 million for 1995-96; For capital, £3 million in 1991-92, £6 million in 1992-93, £37 million in 1993-94, £50 million for 1994-95, and an estimated £53 million for 1995-96). Figures for all receipts and charges for future years are provisional estimates.

(3) Provision for capital spending within GMS cash-limited expenditure (£44 million in 1991-92, £23 million in 1992-93 and £21 million in 1993-94), included in HCHS capital here, is included in HCHS current in Table 1 and Annex A.

(4) HCHS capital includes all NHS trust capital expenditure, ie that funded from charges to health care purchasers (see Note 1) and that financed from their EFLs (£-24 million in 1991-92, £223 million in 1992-93, £304 million in 1993-94, £598 million in 1994-95, an estimated £648 million in 1995-96, and provisional figures in 1996-97, 1997-98 and 1998-99.

(5) Expenditure on drugs prescribed by GP fundholders (£125 million in 1991-92, £295 million 1992-93, £628 million in 1993-94, £1,058 million in 1994-95, and £1,403 million in 1995-96), included here in FHS non-cash limited current, is included in HCHS Current in Table 1 and Annex A for those years. Since decisions on the number of GP fundholders in future years have not yet been taken, all FHS drug costs from 1995-96 onwards are included in the non-cash limited provision.

(6) Prior to 1993-94, MCA figures are included in departmental administration. MCA figures from 1993-94 reflect the reclassification of expenditure following the move to trading fund status.

Table 3 and its supporting text do not pick up changes made in Spring Supplementary Estimates 1995-96.

2.5 **Table 4** compares net expenditure on the NHS in 1995-96 and the planned expenditure for 1996-97 with the figures published in last year's Departmental Report (Cm 2812).

Table 4 Comparison of Expenditure Plans for 1995-96 and 1996-97 with those in Last Year's Departmental Report (Cm 2812)

£m	1995-96 Cm 2812	1995-96 difference	1995-96 Table 3	1996-97 Cm 2812	1996-97 difference	1996-97 Table 3
HCHS current	22,163	154	22,317	22,677	504	23,181
HCHS capital	1,783	23	1,806	1,802	-259	1,543
FHS current	7,024	-7	7,017	7,363	131	7,494
CHMS	732	-224	508	770	-243	527
Departmental administration [1]	269	56	325	325	-16	309
NHS total	31,971	1	31,972	32,937	117	33,054

(1) For consistency, includes MCA

2.6 The main areas of change (£10 million or over) to the spending plans for the various parts of the programme are as follows.

1995-96

HCHS current: £154m
-59 Transfer to DH Admin for Regional Office functions
195 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority from CHMS
10 Transfer to cash-limited London Initiative Zone for primary care improvements

HCHS capital: £23m
23 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority from CHMS

Departmental administration: £56m
59 Transfer from HCHS current for Regional Office functions

CHMS: -£224m
-218 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority to HCHS

1996-97

HCHS current: £504m
305 Change agreed in 1995 Public Expenditure Survey
197 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority from CHMS

HCHS capital: -£259m
-282 Change agreed in 1995 Public Expenditure Survey
23 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority from CHMS

FHS: £131m
127 Change agreed in 1995 Public Expenditure Survey

Departmental administration: £-16m
-10 Change agreed in 1995 Public Expenditure Survey

CHMS: £-243m
-220 Transfer of admin costs for the Prescription Pricing Authority, Dental Practice Board and Special Hospitals Service Authority to HCHS
-9 Change agreed in 1995 Public Expenditure Survey
-11 Adjustment for UK cost of financing EC health programmes

Sources of Finance

2.7 The NHS is financed mainly through general taxation and an element of National Insurance Contributions. In 1995-96 it is estimated that 94.3 per cent of gross NHS spending in England will be met from these two sources: 82.1 per cent from the Consolidated Fund, that is, from general taxation, and 12.2 per cent from the NHS element of National Insurance contributions. Decisions taken in the annual public spending round relate to the total amount of spending to be financed through public expenditure. Changes in the sums raised by the NHS element of National Insurance contributions (for example, because of an increase in earnings) therefore do not in themselves provide more or fewer resources for the NHS in total, but merely change the balance of funding between the taxpayer and the contributor. The remainder of NHS expenditure comes from charges and receipts, including land sales and the proceeds of income generation schemes (see **Figure 1**). **Table 5** shows how sources of finance have changed over time.

Figure 1 NHS Sources of Finance in 1994-95

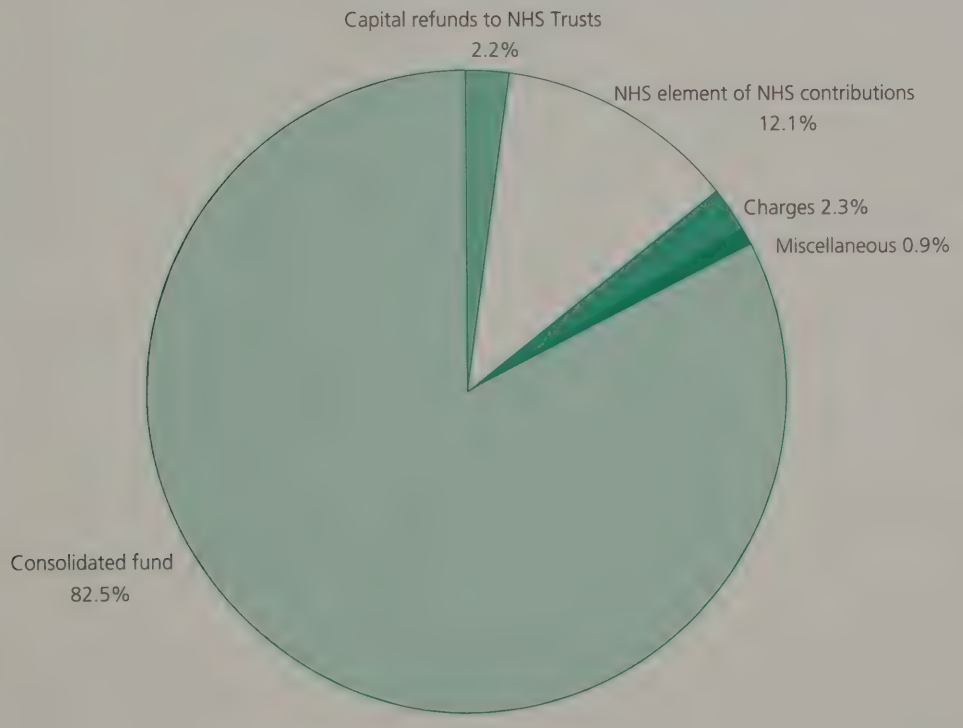


Table 5 NHS Sources of Finance [1]

Percentages

Financial Year	Total public	of which: Consolidated Fund Expenditure	of which: NHS Contributions	Total from other sources	Charges [2]	of which: Capital refunds to NHS Trusts [3]	Miscellaneous [4]
1987-88	95.7	82.2	13.5	4.3	2.9	-	1.4
1988-89	95.2	80.1	15.1	4.8	3.1	-	1.7
1989-90	94.1	77.5	16.6	5.9	4.5	-	1.4
1990-91	94.4	78.7	15.7	5.7	4.5	-	1.2
1991-92	94.8	80.8	14.0	5.2	4.1	-	1.1
1992-93	94.9	81.7	13.2	5.1	3.7	-	1.4
1993-94	95.7	82.7	13.0	4.3	2.3	1.2	0.8
1994-95	94.6	82.5	12.1	5.4	2.3	2.2	0.9
1995-96 estimate	94.3	82.1	12.2	5.7	2.3	2.5	0.9
1996-97 estimate	94.0	n/a	n/a	6.0	n/a	n/a	n/a
1997-98 estimate	94.0	n/a	n/a	6.0	n/a	n/a	n/a
1998-99 estimate	94.0	n/a	n/a	6.0	n/a	n/a	n/a

(1) Figures for 1995-96 to 1998-99 are based upon gross and net data provided in Table 3

(2) The increase in the proportion contributed by charges from 1989-90 is mainly attributable to increased income from private patient charges. This in turn is the result of provisions in the Health and Medicines Act 1988 which allow health authorities to set their own charges for private patients at commercial rates.

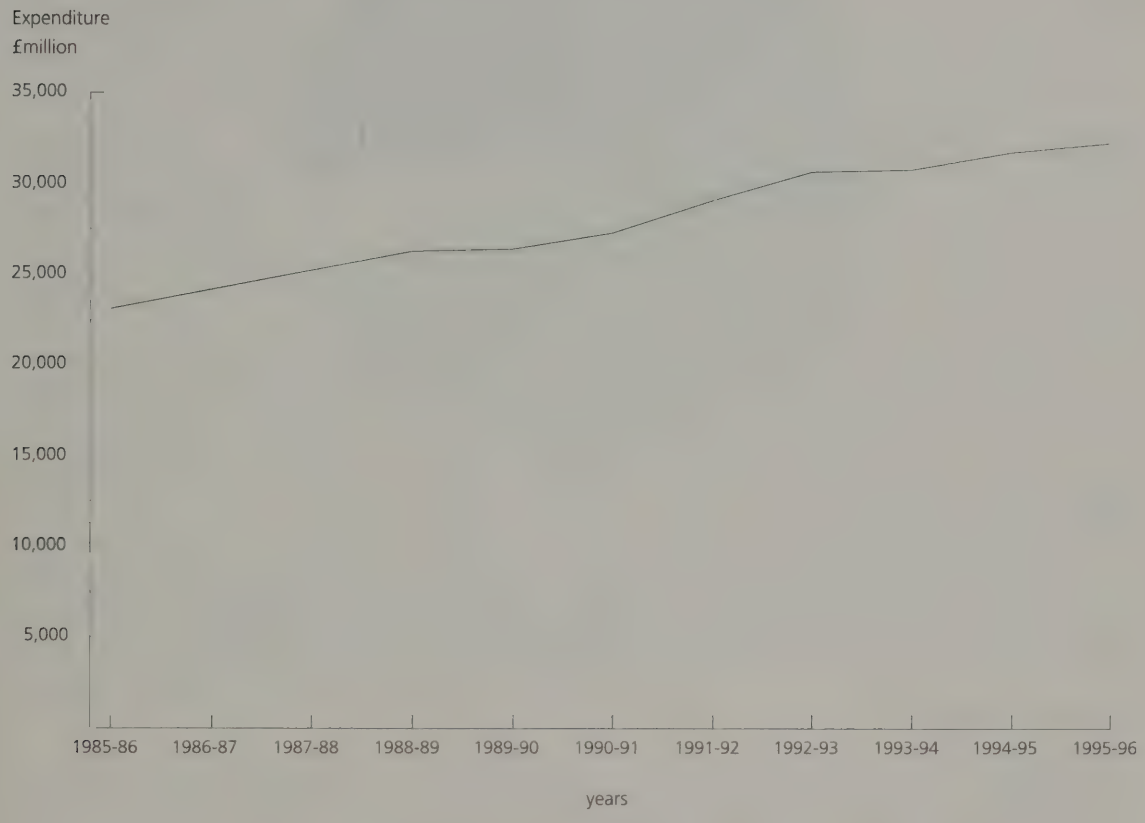
(3) Capital refunds to NHS trusts were not identified separately prior to 1993-94.

(4) Mainly HA capital receipts

Recent Expenditure Trends

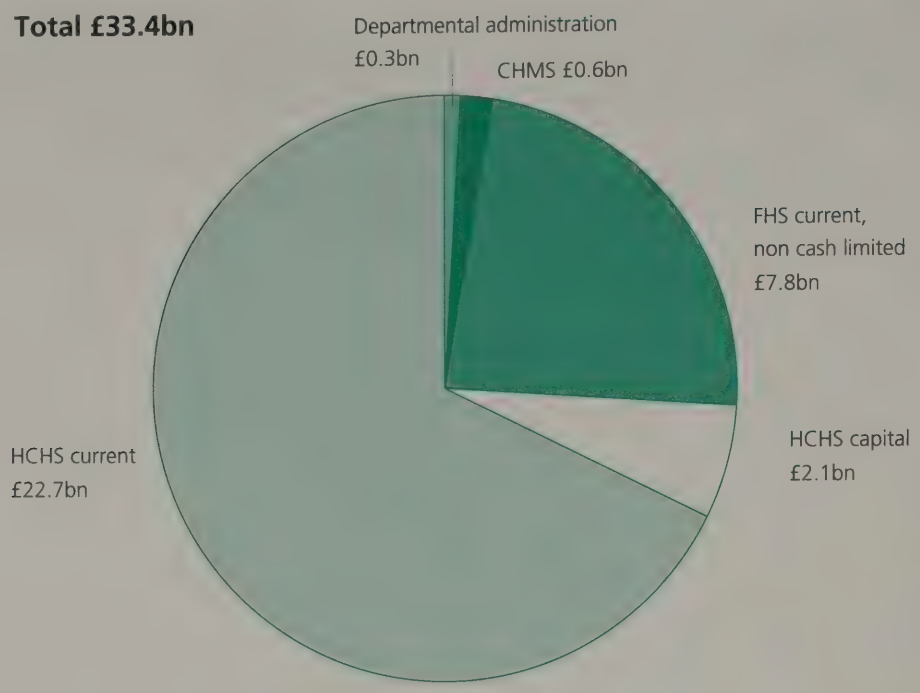
2.8 Net expenditure on the NHS in 1995-96 is forecast to be £31,972 million, an increase of 41.5 per cent in real terms (measured by the GDP deflator) since 1985-86. The equivalent gross figure is forecast to be £33,424 million. **Figure 2** shows how NHS expenditure has grown in real terms.

Figure 2 Growth in NHS Gross Expenditure (1994-95 prices)



2.9 The largest part of NHS spending is on the Hospital and Community Health Services: forecast at £22,665 million on current and £2,065 million on capital in 1995-96. Within the HCHS total, £862 million is forecast for FHS cash limited spending including infrastructure support for GP fundholders. The total non-cash limited Family Health Services account for £7.8 billion. The remainder will be spent on the Central Health and Miscellaneous Services and Departmental Administration (see **Figure 3**).

Figure 3 NHS Gross Expenditure 1995-96



Personal Social Services

2.10 The Department of Health is also responsible for determining the necessary resources for the delivery of high quality social care through local authorities and other agencies. Full details of the range of services provided and how they are resourced are contained in chapter 5.

PSS Expenditure

2.11 **Table 6** shows total local authority current and capital expenditure on personal social services (PSS). Local authority PSS net expenditure has increased by 95 per cent in real terms between 1983-84 (when it was £2,132 million) and 1995-96 (budgeted expenditure was £7,323 million). There has been a substantial increase in current expenditure since 1992-93, which reflects, among other things, the new responsibilities placed on local authorities as a result of the community care reforms which took place on 1 April 1993. Capital expenditure increased by 22 per cent in real terms between 1983-84 and 1994-95. This is less than the growth in revenue expenditure which is consistent with the shift in local authorities' role from being a provider of service and therefore needing to maintain and invest in their own estate to becoming purchasers from the independent sector.

Table 6: Expenditure on Local Authority Personal Social Services

£ million

	1983/84 outturn	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 estimated outturn	1995-96 budget
Current expenditure							
gross[1]	2,491	4,698	5,127	5,470	6278		
charges[1]	353	485	506	502	621		
net[2]							
cash	2,138	4,213	4,622	4,968	5,657	6,643	7,323
real terms[3]	3,774	5,018	5,182	5,352	5,921	6,826	7,323
Capital expenditure							
gross	90	174	166	169	185	189	208
income	17	27	34	38	69	41	38
net	73	147	133	132	116	148	170
Total local authority expenditure							
gross [1]	2,581	4,872	5,294	5,639	6,463		
charges/income [1]	370	512	540	540	690		
net	2,211	4,360	4,755	5,100	5,773	6,791	7,493

(1) Net figures only available for 1994-95 and 1995-96.

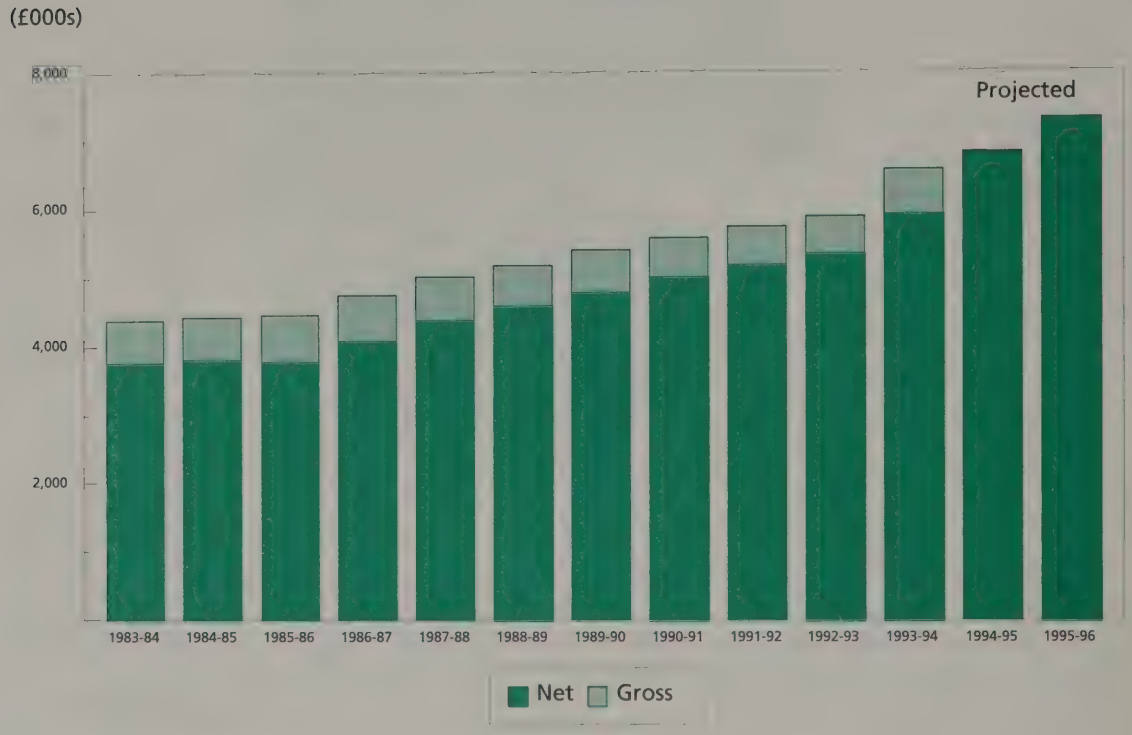
(2) Excluding capitalised current expenditure, mainly redundancy payments, for 1992-93, 1993-94 and 1994-95 which are included in table 2.

(3) Cash figures revalued to average 1995-96 prices using Gross Domestic Product deflator.

(4) The above figures are inclusive of grants from central government

2.12 The growth in net and gross revenue expenditure is illustrated in **Figure 4**. Over the period since 1983-84 gross expenditure has increased at a slightly faster rate than net expenditure. This would indicate that local authorities have increased their income from charges over the period. Most local authorities now make some charge for the services that they provide for adults.

Figure 4 - Growth in Real Terms in Gross and Net Current Expenditure on Personal Social Services 1983-84 to 1995-96



(1) Only net figures are available for 1994-95 and 1995-96

2.13 Details of spending, performance and value for money against each of the sub-programmes are contained in chapters 3, 4, 5 and 6.

3 PUBLIC HEALTH

The Department's Public Health Role

3.1 The Department's Public Health Group is responsible for the development and implementation of coherent policies to prevent disease, prolong life, identify emerging public health issues, and promote and protect the health of the public.

3.2 The Department sponsors and collects a wide range of information relevant to public health, through the NHS and by commissioning surveys of the general population. It also makes extensive use of the information collected by OPCS. This information is used in the development and monitoring of its own policies, and to provide comparative information to the NHS and others, in support of a wide range of activities at local level. Provision for the objectives in this chapter appears in the 1996-97 Main Estimates for Class XI, Vote 2.

3.3 The key objectives of the Public Health Group are to:

- provide overall direction and oversight to the Government's Health of the Nation Strategy, and contribute specifically to achieving the Health of the Nation targets relating to substance misuse, diet and nutrition, accidents, skin cancer and sexual health.

- monitor and survey the health of the population, secure expert advice, and act to protect and improve it taking into account new developments and ethical considerations.

- improve knowledge on the safety of food and water, implement ways to reduce risk and develop a sensible risk-related approach to deregulation, and minimise adverse effects by coordinating, where necessary, outbreak management.

- survey, and where appropriate respond to, specific hazards (chemical, microbiological and radioactive) to health in the environment; consider with other Government Departments, Local Authorities and Health Authorities the further needs for central monitoring and surveillance and central advice on chemical episodes.

- strengthen arrangements for controlling communicable diseases (including Infectious Disease, Port Health, HIV/AIDS), develop and implement appropriate immunisation policies where available, and provide information in this area to facilitate the protection of public health.

- deliver the Departmental obligations set out in the Government White Paper 'Tackling Drugs Together', including in particular the publicity strategy and providing guidance to purchasers in the light of the forthcoming report of the Task Force on the Effectiveness of Drug Services.

- ensure that requirements placed on the Secretary of State by the Abortion Act and the Human Fertilisation and Embryology Act are met.

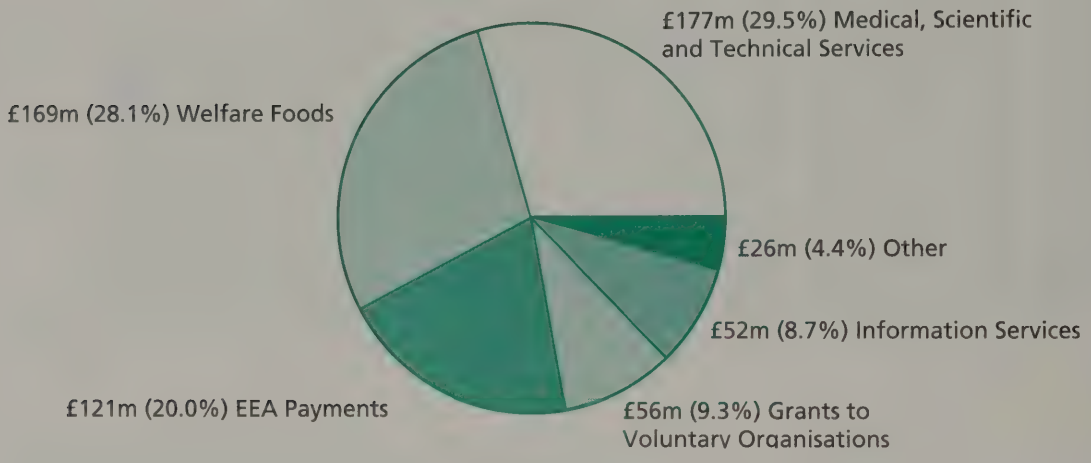
3.4 The safety of medicines and of medical devices is the responsibility of two executive agencies of the Department - the Medicines Control Agency and the Medical Devices Agency. More information about their work is contained in **Annex G**.

Management and Resources

3.5 In carrying out its responsibilities, the Public Health Group works closely with other Government Departments and agencies, non-departmental public bodies, the NHS, the European Commission and member states of the European Union, local authorities, the voluntary sector, health professional bodies, international agencies and the public.

3.6 The great majority of DH programme expenditure on public health functions is subsumed within NHS general funding. Additionally, some direct expenditure is contained within the Central Health and Miscellaneous Services budget (see para 2.9 and **Annex H**). Principal public health spending within that budget is as follows:

Figure 5 - Central Health and Miscellaneous Services Gross Expenditure 1995-95 (Estimate)



3.7 The **welfare food programme** provides entitlement to free liquid and dried milk and vitamins for families with children under five and expectant mothers in receipt of Income Support, and to subsidised dried milk for families with children under one in receipt of Family Credit. The programme also provides one third of a pint of free milk daily to children under five in non-residential day care. Expenditure on **European Economic Area (EEA) medical costs** is for treatment given to UK nationals by other member states: this continues to grow as a result of increases both in the number of people treated and in the treatment costs of member states. Some 83% of expenditure on **medical, scientific and technical services** is for the Public Health Laboratory Service Board, the National Biological Standards Board, the Microbiological Research Authority and the National Radiological Protection Board, four non-departmental public bodies whose functions are described in Annex H. **Grants to voluntary organisations** go primarily to national voluntary organisations, across the spectrum of health and social services activity. **The Health Education Authority (HEA)** provides information and advice about health directly to the public; supports other organisations and health professionals who provide education to the public; and advises the Secretary of State on matters relating to health education. In December 1994, Ministers announced a major change in the way in which the HEA will be funded from April 1996 and the opening up of this budget to other providers through competitive tendering (see Annex H).

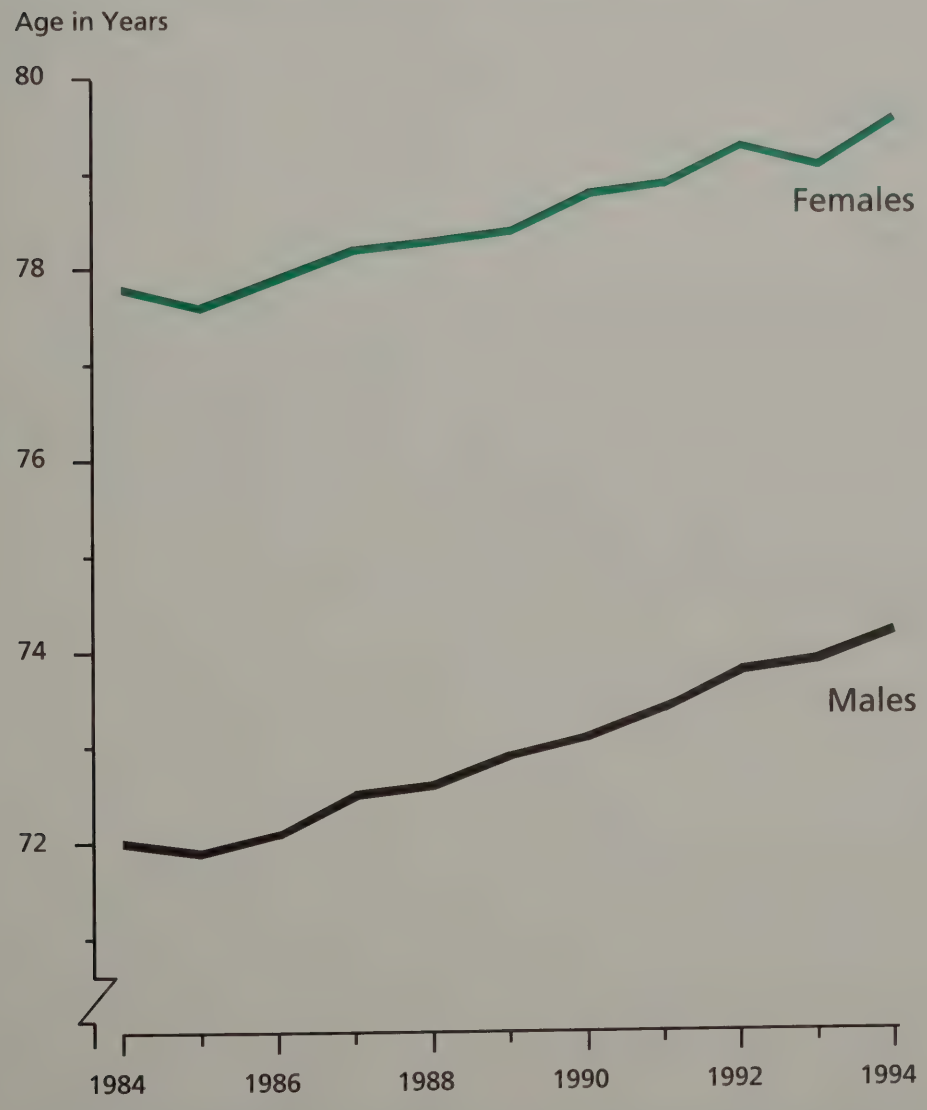
Background - Recent Trends in Mortality and Life Expectancy

3.8 Mortality rates for 1994 showed a substantial fall over 1993 levels, the largest falls being in childhood mortality rates which fell by 10 per cent in boys and 9 per cent in girls. The longer term trends in mortality are also encouraging with falls between 1984 and 1994 in all age groups for males and females. Largest falls occurred in childhood with mortality rates for the 1-14 year age group declining by 34 per cent in boys and 30 per cent in girls. The rise in mortality rates which occurred in young adult males during the latter part of the 1980s has now reversed with rates falling in each year since 1990. Nevertheless mortality rates in males aged 15-44 years are currently only slightly below their 1984 levels.

3.9 Infant mortality rates have continued to decline. Rates fell from 6.5 deaths per 1000 live births in 1992 to 6.3 in 1993 and 6.1 in 1994. Rates are now 35 per cent below their level in 1984. A major contributor to this decline is a fall in postneonatal mortality - deaths between 28 days and under 1 year - which has fallen consistently every year since 1988. Much of this fall is attributable to a 71 per cent decline in the postneonatal sudden infant death ('cot death') mortality rate over this period, although there have also been reductions in other major causes of postneonatal deaths.

3.10 Substantial falls in deaths from coronary heart disease, strokes, and several types of cancer have contributed to the expectation of life at birth now reaching its highest ever levels in England and Wales - in 1994 estimated to be 74.2 years for males and 79.6 years for females (see **Figure 6**). To what extent the years of extra life are lived in good health is the subject of continuing study in the UK and elsewhere.

Figure 6 Life Expectancy at Birth in England 1984-1994



RECENT PERFORMANCE AND FUTURE PLANS

Policy Appraisal and Health

3.11 Guidance on Policy Appraisal and Health was published in December 1995. This guide is designed to give practical guidance to Government Departments and other public sector agencies on how to assess the impact of their policies on health. It describes how to incorporate health impacts into the wider assessments of costs and benefits required for policy development. The advice is intended to be helpful and to encourage consistency throughout the public sector but is not mandatory.

Research

3.12 Part of the purpose of the Department's centrally commissioned research programme is to provide, through high quality research, a knowledge base for central policies directed at the health of the population as a whole. Since 1993, emphasis has been placed on a more limited range of strategic objectives to strengthen the impact of centrally commissioned research.

3.13 Much of the Department's research in the field of public and environmental health is carried out by bodies such as the Centre for Applied Microbiology and Research (CAMR), the Public Health Laboratory Service, the National Biological Standards Board and the National Radiological Protection Board, partly in support of their own functions. The Department directly funds research at CAMR in support of a wide range of public health issues, for example into new vaccines. The centrally commissioned programme supports research in areas not funded by these bodies. Current projects will be augmented in future with strategic initiatives on:

- variations in health;
- nutrition;
- environmental health;
- individual health behaviour.

Health of the Nation

3.14 A key objective of the Department of Health, and in particular the Public Health Group, is to provide overall direction and oversight to the Government's Health of the Nation (HoN) strategy. The strategy focuses on five key areas - coronary heart disease and stroke; cancers; mental illness; HIV/AIDS and sexual health; and accidents. Three years into the strategy, progress towards the Health of the Nation targets has been encouraging. For most of the targets for which monitoring information is available, progress to date has been in the right direction. The strategy is in its early stages but it is clear that the targets are acting as an effective tool to focus attention where it is needed. There have already been some notable successes:

- The target for the incidence of gonorrhoea (a proxy for HIV) has been achieved ahead of schedule.
- There is evidence of a significant and welcome drop in suicide rates in 1994.

3.15 There are three targets which present particular challenges:

- The prevalence of smoking among schoolchildren has increased and the target for 1994 was not met.

- Obesity, which increases the risk of coronary heart disease and stroke, has been increasing among men and women since the mid 1980s. The actions to address this would be expected to take some years to show any effect, and the target has therefore been set for the year 2005 by which time any results of these policies should be apparent.

- The latest figures for lung cancer mortality among women aged under 75 show a small increase. It is hoped that the fall in smoking levels among adult females will lead to a reduction in female lung cancer rates in future years.

Independent interim review of the Health of the Nation strategy

3.16 Ministers have decided that the Department should commission an independent interim review of The Health of the Nation strategy. The project will be advertised for tender and should report to the CMO in early 1988.

3.17 Progress towards the primary Health of the Nation targets in England is set out in **Table 7**. Progress on the Health of the Nation strategy more widely is set out in detail in 'Fit for the Future' (Department of Health, July 1995).

Table 7 Progress towards the primary Health of the Nation targets England

TARGET NUMBER	TARGET		TARGET YEAR	MOVEMENT TOWARDS TARGET	MOVEMENT AWAY FROM TARGET
A1	CHD under 65 yrs		2000	✓	
A2	CHD 65-74 yrs		2000	✓	
A3	Stroke under 65 yrs		2000	✓	
A4	Stroke 65-74 yrs		2000	✓	
A5/B6	Cigarette Smoking	Males	2000	✓	
		Females		✓	
A6	Blood Pressure*		2005		
A7	% Obese		2005		✓
A8	% Energy from Saturated Fat		2005	✓	
A9	% Energy from Total Fat		2005	✓	
A10	Drinking*	Males	2005		
		Females			
B1	Breast Cancer, 50-69 yrs		2000	✓	
B2	Cervical Cancer, Incidence		2000		
B3	Skin Cancer, Incidence		2005		
B4	Lung Cancer, Men under 76 yrs		2010	✓	
B5	Lung Cancer, Women under 76 yrs*		2010		
B7	Giving Up Smoking in Pregnancy		2000	✓	
B8	Cigarette Consumption		2000	✓	
B9	Smoking 11-15 yrs		1994		✓
C1	Mental Illness - Health and Social		-		
C2	Suicide, All ages		2000	✓	
C3	Mental Illness - Suicide		2000		
D1	Gonorrhoea, New Cases		1995	✓	
D2	Drug Misusers - Shared Needles		1997 & 2000		
D3	Conceptions under 16 yrs		2000	✓	
E1	Accidents under 15 yrs		2005	✓	
E2	Accidents 15-24 yrs		2005	✓	
E3	Accidents, 65 yrs and over		2005	✓	

Note that, in some cases, the latest available data pre-date or overlap with the start of the strategy. The impact of the strategy will therefore not yet be evident in these cases.

Assessment of whether the movement is in the desired direction towards the target is based on a comparison of the latest available data with the baseline as defined in the "Specification of National Indicators" (Monitoring systems are being put in place for targets where data are not yet available)

*For targets A6 and A10 the differences between the latest data and the baselines are not statistically significant.

For target B5, no clear pattern of movement from the baseline has yet emerged

3.18 Some key aspects of recent performance and future plans include the following:

Teenage Conceptions

3.19 The latest figures (1993) show that conception rates amongst girls under 16 have fallen for the third year running and by a total of 20 per cent over those three years. This encouraging reduction has reversed the upward trend of the 1980s and reflects considerable effort on the part of all those who provide help and advice to young people. Action in hand to maintain this downward trend includes Sexwise, a free information phoneline for young people which has received 180,000 calls in its first 8 months of operation; production of a compendium of examples of young people's family planning services for the NHS; and continuing work with the Department for Education and Employment and Office of Standards in Education (OFSTED) to encourage effective sex education in schools.

Smoking

3.20 The 1994 General Household Survey confirms that smoking prevalence among adults is continuing to fall, from 28 per cent in 1992 to 26 per cent in 1994 (England). By sex, the figures are that 28 per cent of men smoked in 1994, from 29 per cent in 1992, and 25 per cent of women (from 27 per cent). The second year of the National Smoking Education Campaign, run by the HEA, has included the launch of a freephone helpline for smokers and a national TV advertising campaign. The third phase of the National Smoking Education Campaign will begin in 1996-97, based on research into the effectiveness of previous activities.

3.21 Smoking rates in 11-14 year olds have increased slightly from 10 per cent in 1993 to 12 per cent in 1994. This is disappointing given the continuing fall in adult prevalence. The Government's comprehensive strategy to reduce smoking has continued, including increases in tobacco taxation, maintaining controls on advertising and illegal sales and a national HEA campaign focused on teenagers, as well as targeting of parents in adult smoking education. Following competitive tender, a new three year education campaign for teenagers will be launched in 1996.

3.22 A new agreement with the tobacco industry on the use of additives in tobacco products will be introduced.

Alcohol

3.23 In 1995-96 the report of the Interdepartmental Group on Sensible Drinking was prepared and published. This group was set up to review the sensible drinking message in the light of the latest scientific evidence. Its report recommends a small increase in the present recommended sensible drinking levels. It suggest that new advice should be in the form of a daily benchmark rather than weekly levels. It says that there is evidence that drinking one or two units of alcohol a day gives a significant health benefit in reducing the risk of coronary heart disease for men over 40 and post-menopausal women. The report also concluded that men who drink more than 3 to 4 units a day and women who drink more than 2 to 3 units a day run an increasingly significant risk of illness and death from a number of conditions, including haemorrhagic stroke, some cancers, accidents and hypertension.

3.24 In 1996-97 and beyond, the Public Health Group will:

- reappraise the place of alcohol in The Health of the Nation
- commission new health promotion messages based on the Interdepartmental Group Report, and a relaunch of the publicity campaign based on new messages
- put in place new arrangements for dissemination of good practice in both care and treatment and health promotion to purchasers in both NHS and social services.

Physical Activity

3.25 Physical inactivity is one of the four major preventable risk factors for Coronary Health Disease and Stroke. Physical Activity levels in adults were surveyed in 1991 and found to be low, with over 70 per cent of men and 80 per cent of women taking insufficient activity to have a health benefit. However, over 60 per cent of all adults thought they were fit. In 1993, under the HoN umbrella, a Physical Activity Task Force was set up with wide representation from eight government departments, the HEA, the Sports Council and voluntary and academic bodies. In May 1995 the task force issued a consultation document which contained two main innovations. Firstly that moderate activity is beneficial for preventing CHD and Stroke and secondly that the Department should be concentrating its efforts on the least active. In March 1996, a national Physical Activity campaign "Active for Life" will be launched to promoted activity among this group.

Nutrition

3.26 The Health of the Nation includes diet and nutrition targets to help achieve reductions in coronary heart disease and stroke, including a target for the reduction of obesity. The Nutrition Task Force was set up for a time-limited period to set in train a programme of work to help achieve the targets. A report on the progress of the programme will be published in 1996-97.

3.27 The Committee on the Medical Aspects of Food Policy continues to provide expert advice on the link between diet and health. It is currently reviewing the nutritional aspects of cancer and criteria for the nutritional assessment of Infant Formula. Reports are expected in 1996-97. The National Diet and Nutrition Survey, conducted jointly with the Ministry of Agriculture Fisheries and Food, continues. The results of the survey of children aged 1½ to 4½ were published in 1995-96; fieldwork for the survey of people aged 65 and over was completed. The survey of children aged 4-18 years is due to begin in 1996-97.

3.28 Folic acid taken around the time of conception and in the very early weeks of pregnancy can help to prevent spina bifida and other similar deformities. The Department is funding a £2.3 million education campaign which began in November 1995. It aims to inform women intending to become pregnant of the benefits of folic acid supplements.

Ethnic Minority Health

3.29 There are marked variations in the pattern of health and disease between the different ethnic minority groups and the population as a whole in this country. This is particularly noticeable in the Health of the Nation key areas. Cultural differences also affect the use of health services by the ethnic minorities.

3.30 To improve the health and healthcare of ethnic minority communities, Ministers established the NHS Ethnic Health Unit in 1994 to work with Health Authorities, Trusts and GPs through the development of purchasing, primary care and implementation of the Health of the Nation. The NHS Ethnic Health Unit primarily works by enlarging the NHS knowledge base on ethnicity and funding project partnerships between the NHS and local minority ethnic groups. These give local people greater voice in shaping health services, commissioning and delivery on issues of needs, access and quality. The wider Department of Health has provided funding for a number of projects to the black and ethnic minority voluntary sector to ensure better communication on health and disease patterns within the communities, and to develop good practice in these areas. To promote this work the Department has also funded the establishment of a consortium of voluntary organisations, which include Asian, Chinese, Caribbean and African organisations, to examine the potential for their greater involvement in work to improve health among these communities. A report on the findings of the consortium will be published and disseminated widely. The Department will examine what further support needs to be provided to the voluntary sector in the light of the project's findings. The Department is also funding the development of capacity building courses for voluntary organisations to enable them to undertake further Health of the Nation work.

Health of the Young Nation

3.31 In June 1995, the Department launched 'Health of the Young Nation', a new initiative within the Health of the Nation strategy to improve the health and well being of young people. A competitive tender exercise will be used to select a body to coordinate a network of those working to promote the health of adolescents in a wide variety of settings - health and local authority services, schools, the youth service, the voluntary sector and elsewhere. The main purpose of the network will be to improve knowledge and understanding about what is and is not effective in promoting health among this age-group, and to stimulate and disseminate ideas and good practice.

Variations in Health

3.32 Across the developed world, there are variations in health between different population groups which are associated with a range of factors. The Chief Medical Officer set up a Working Group to look at what the NHS and the Department of Health could do, within the Health of the Nation key areas, to tackle ethnic, geographical, socio-economic and gender variations in health status, and advise on what further research was needed. The group's report was published in October 1995 and was distributed throughout the NHS. It drew particular attention to the need to evaluate the effectiveness and cost-effectiveness of interventions designed to reduce health variations. The Department is to launch a £2.4 million research initiative on health variations in early 1996.

Communicable Diseases (including HIV and AIDS)

3.33 During 1995-96 the childhood immunisation programme continued to be successful, with continuing high immunisation uptake and the incidence of disease at its lowest ever levels. Immunisation uptake rates for April to June 1995 at age 24 months were 95.8 per cent for diphtheria/tetanus/polio, 93.5 per cent for pertussis, 94.9 per cent for Hib and 92.5 per cent for measles, mumps and rubella (MMR), with excellent prospects for reaching the 95 per cent 1995 targets. Since the beginning of 1995, there have been only three confirmed cases of measles in the age group covered by the very successful 1994 measles/rubella (MR) campaign: these were in children who were not immunised. During 1995-96, the Department continued intensive monitoring, surveillance and assessment of the campaign, including investigation of suspected adverse reactions. The number of measles cases fell to an all time low; adverse reactions to the MR vaccine were shown to be rare (with serious events extremely rare); and the new method of salivary diagnosis of measles, developed by the Public Health Laboratory Service (PHLS), was highly successful.

3.34 In 1995, in the light of the high coverage achieved in the measles/rubella campaign and the continuing high uptake of MMR vaccine in children aged 12 to 15 months, the Department implemented the recommendation from the Joint Committee on Vaccination and Immunisation that rubella vaccine should no longer be routinely offered to girls at 10 to 14 years. At the same time, the Department confirmed the need to ensure that MMR vaccine was offered to any children who had not been immunised and that all women of childbearing age are both screened for rubella antibodies and offered immunisation where and when appropriate. Policy on these aspects remained unchanged.

3.35 The United Kingdom has an excellent record of tuberculosis (TB) control. However, the worldwide resurgence in TB over recent years has had a small but important impact on trends in this country. In response to this, the Government established an Interdepartmental Working Group on Tuberculosis with a remit to consider policies for TB control and to recommend best practice. The Working Group focused on matters such as screening, prevention and treatment for groups at high risk, including homeless people and immigrants.

3.36 The Department continues to promote the health of travellers through the leaflets "Travelsafe" (which provides information on HIV/AIDS) and "Health Advice to Travellers" (which covers diseases more generally), and the Prestel database, an on-screen database widely used by travel agents which has been used to convey health messages relating to travel overseas. In September the Department published a new more detailed guidance entitled "Health Information for Overseas Travel". This book, available through HMSO, provides country by country information on health risks, immunisation and malaria prophylaxis and other preventive measures, as well as chapters on specific health risks. All GPs and public health doctors received a copy of the publication which is a companion volume to the Department's memorandum "Immunisation Against Infectious Disease".

3.37 The Department continued to encourage the uptake of influenza vaccine in those considered to be at greatest risk of serious complications from influenza by issuing a new patient information leaflet, 'What should I do about 'flu?', together with a video advertisement for Post Offices in the autumn of 1995. The leaflet also provided guidance on what a person with influenza should do. Guidance for doctors to help them plan their immunisation programmes well ahead of the influenza season was issued in the summer.

3.38 A summary report of projections of the number of people with AIDS and other forms of severe HIV disease from 1995 to the end of 1999 was published on 21 November. The latest projections for the overall level of new cases in each year are lower than the last set of projections which were produced in 1993, and show that new AIDS cases among gay and bisexual men are expected to fall from the 1994 level, but new AIDS cases from heterosexual contact are expected to increase. Levels among intravenous drug users are low, but there may be a slight increase among this group. The total number of people with AIDS and other forms of severe HIV disease at the end of each year is expected to increase and to reach more than 8,000 by the end of 1999. The full report was published in January 1996.

3.39 The Report from the Group set up to review the HIV & AIDS health promotion strategy was published on 27 November 1995. As the title ("HIV & AIDS Health Promotion : An Evolving Strategy") implies. the Report builds on the existing strategy and, informed by the current pattern of spread of HIV, provides useful sharpening of focus. Campaigns will continue to maintain awareness of HIV in the general population but greater emphasis will in future be placed on developing national and local health promotion directed at vulnerable groups. The revised strategy also recognises that some health promotion work with specific messages for targeted audiences may best be undertaken by voluntary or self-help groups from vulnerable groups themselves.

3.40 The latest report from the Unlinked Anonymous HIV Surveys Steering Group which provides data to the end of 1994 was published in December 1995. The latest results show that there is wide dissemination of HIV infection throughout England and Wales among those groups at greatest risk but rates are much higher in London. This report confirms that transmission is still occurring among some homosexual/bisexual men, especially those under 25, and that injecting drug users are still participating in high risk behaviour with younger users and women in particular sharing injecting equipment. Results from the surveys in pregnant women show a much lower level of HIV infection than in the more behaviourally vulnerable groups, however there are sustained high levels in London. Results from these surveys provide an important source of data to inform AIDS projections are used for local needs assessment and targeting prevention activities.

Drug and Solvent Misuse

3.41 The Department is playing an important role in delivering the Government's Drugs Strategy, "Tackling Drugs Together". The strategy's goals are to increase the safety of communities from drug-related crime, reduce the acceptability and availability of drugs to young people, and reduce the health risks and other damage related to drug misuse. As part of this work in 1995-96, the Department:

- has established a 24 hour free national telephone helpline for drugs misusers, their friends and families;
- has set up a Task Force to review the effectiveness of treatment services;
- has provided £1 million for initiatives aimed at young people;
- has run a national anti-solvent misuse television campaign which shows a strong correlation with the drop in deaths from this cause from 122 in 1991 to 73 in 1993;
- is co-ordinating the Government's publicity strategy, through a contract with the Health Education Authority; and
- is developing an information strategy to support the Drugs Strategy and share information with European Union Member States.

3.42 Priorities for 1996-97 include continuing to develop and monitor work flowing from "Tackling Drugs Together", working with other European Union Member States to ensure an appropriate level of international co-operation; and issuing guidance to purchasers of drugs services in the light of the Effectiveness Task Force report.

Environmental Health

Air Pollution

3.43 Three major reports, prepared by DH Expert Advisers, were published during 1995-96. These dealt with particulate air pollution; asthma and air pollution; and the effects of exposures to mixtures of air pollutants. The reports were well received and clarified a number of difficult areas. In addition a series of recommendations for air quality standards has been made by the Department of Environment Expert Panel on Air Quality Standards, basing its recommendations on the advice of DH committees. The recommended standards are amongst some of the newest and tightest in Europe.

3.44 DH, together with the Department of the Environment and the Medical Research Council, announced a major research initiative on air pollution and respiratory disease. A total of up to £5 million is available over four to five years for suitable projects. DH has made its usual contribution to international activities in the air pollution area including the revision of the World Health Organisation Air Quality Guidelines for Europe.

3.45 On 23 November 1995 the DH and DoE held a conference on "Asthma: Possible Causes, Successful Management" at the Queen Elizabeth II Conference Centre in association with the National Asthma Campaign and the Institute for Environment and Health.

UK Environment and Health Action Plan

3.46 The Second European Conference on Environment and Health (Helsinki 1994) agreed the Environment and Health Action Plan for Europe (EHAPE), containing a commitment that countries would prepare National Environmental Health Action Plans by 1997. The UK was one of six countries invited to participate in a pilot project. The DoE and DH worked closely together and, in August 1995, published a draft of the UK Action Plan (UKEHAP) for public consultation. The final text of the Action Plan, taking account where possible of comments received, is expected to be published by the summer of 1996.

Environmental Microbiology

3.47 The Department has continued to influence national and international public health activity with regard to microbiological aspects of the environment and water. The Expert Group on *Cryptosporidium* has produced its second major report on *Cryptosporidium* in water supplies.

Biotechnology

3.48 The Department's Biotechnology Unit has continued to develop its influence both nationally and internationally. The UK has been elected chair of the Organisation of Economic Co-operation and Development's (OECD) Working Party on Biotechnology (WPB), with vice chairs US and Japan, and is co-chair with Japan of its Ad Hoc Task Force on Human Health-Related Biotechnologies. The Department of Health has co-sponsored with Health Canada a prestigious meeting held in Ottawa on gene delivery systems with presentations by most of the major workers in the field worldwide. Future initiatives include projects on economic aspects of human health-related biotechnologies and on transgenic animals.

Microbiological Risk Assessment: Dangerous Pathogens

3.49 The Advisory Committee on Dangerous Pathogens has produced guidance on 'Protection against blood-borne infection in the workplace: HIV and Hepatitis' and 'Categorisation of biological agents according to hazard and categories of containment'. The Committee is finalizing its advice to Government on 'Microbiological Risk Assessment and Public Health'. It is expected that further development of this area will take place in 1996 and beyond. During 1996, the Committee expects to advise Government on Viral Haemorrhagic Fevers; the risks arising from exposure to infections at work to pregnant women and those who have recently given birth; and the containment of animals, focusing primarily on the use of experimentally infected animals in the laboratory setting.

Food Safety

3.50 The Department undertakes a continuing programme of microbiological food surveillance to support its responsibilities for food hygiene legislation. Competitive tendering has been successfully adopted and further opportunities to contract out work will be actively pursued during 1996.

3.51 The last three years have seen the biggest increase in food poisoning notifications since the late 1980's. There is no clear explanation for this rise. Results are expected during 1996 from the Infectious Intestinal Diseases study which, inter alia, will provide for the first time detailed information on the socio-economic costs and main causes of gastrointestinal illness.

3.52 The public health implications of the Bovine Spongiform Encephalopathy (BSE) epidemic in cattle have been kept under close scrutiny. The National Creutzfeldt-Jakob Disease (CJD) Surveillance Unit - which was set up in 1990 - has continued to monitor the pattern of CJD in the UK, paying particular attention to occupation and eating habits, but has found no conclusive evidence of any change in CJD that could be attributable to BSE. It is clear that surveillance will need to continue for some years to come in view of the prolonged incubation periods associated with CJD.

3.53 In June 1995 the Department and MAFF welcomed the Advisory Committee on the Microbiological Safety of Food report on verocytotoxin producing *Escherichia coli* (VTEC). Although VTEC is a relatively rare cause of foodborne illness, it can lead to severe complications. The Report made 20 recommendations aimed at protecting public health, filling gaps in knowledge and developing prevention and control measures. Proposals were invited for research projects as recommended in the report and details of the programme will be announced shortly.

3.54 In the area of food hygiene legislation a range of **deregulation objectives** are being pursued while leaving in place necessary food safety measure.

Ethical Issues

3.55 The Department continues to ensure that the ethical aspects of health care developments and research are properly addressed. Following recommendations of the House of Lords Select Committee on Medical Ethics, it has worked respectively with the British Medical Association and Royal College of Physicians to develop codes of practice on the application of advance directives (so-called "living wills") and handling of persistent vegetative state. Taking account of a series of inquiry reports, guidance on the protection and use of personal information relating to people with a severe mental illness formed part of a Departmental guide, Building Bridges. More general guidance for the NHS on the protection and use of personal information will be issued shortly.

3.56 Gene therapy provides the possibility of extending therapeutic interventions for a range of diseases and disorders for which at present, treatments are unsatisfactory or unavailable. The establishment of the Gene Therapy Advisory Committee in 1993 provided a mechanism by which gene therapy research could be reviewed and given ethical approval. A major funding initiative by the Medical Research Council together with research funding by the voluntary sector, means that gene therapy research protocols will be translated into clinical trials at an increasing rate. Since January 1993, 12 gene therapy research trials have gained ethical approval and at October 1995, a total of 46 patients had undergone gene transfer procedures.

3.57 Advances in human genetics mean that tests will become available which will allow individuals or populations to be tested to see whether they carry genes that may predispose them or their children to particular diseases. The introduction of such tests raises ethical concerns, and in June 1995 the Secretary of State announced the establishment of an advisory committee to oversee genetic testing, whose chairman and terms of reference were announced in January 1996. The Advisory Committee on Genetic Testing will provide a forum in which the ethical, social, and scientific aspects of testing can be reviewed, including consent to testing, the need for counselling, the confidentiality of genetic information and arrangements for test kits sold direct to the public.

Public Health Issues in the European Community

3.58 During 1995, the European Commission continued with the programme of activity laid down in its Communication on the Framework for Action in the Field of Public Health, which provides for cooperation between member states in the field of prevention. Programmes of work were agreed in 1995 on AIDS and communicable diseases; cancer; drug dependence; and health promotion, information, education and training. These programmes will make money available to fund a variety of actions, for example information exchange and dissemination of good practice. They will last for 5 years, and the UK will expect to play an active role in their implementation. The Commission will be required to submit an interim report half-way through the programmes, and a final report on completion. The reports will enable the Council to evaluate the effectiveness of the actions and to discuss the direction and priorities of future programmes.

3.59 The Commission published a proposal on health monitoring in October 1995. The Health Council is expected to give its initial views on the proposal in May 1996. Proposals on pollution-related illnesses, accidents and injuries, and rare diseases are expected in 1996. A Data Protection Directive was agreed in October 1995 and Member States have three years in which to put the Directive into effect. The Department of Health is considering the impact of the Directive on its areas of responsibility and will begin work on an implementation strategy in the UK in relation to health data in 1996.

4 NATIONAL HEALTH SERVICE

Introduction

Purpose of the National Health Service

4.1 The purpose of the NHS is to secure through the resources available, the greatest possible improvement to the physical and mental health of the people of England by promoting health, preventing ill-health, diagnosing and treating disease and injury, and caring for those with long term illness and disability. It provides a service to all on the basis of clinical need, regardless of ability to pay.

4.2 The long term development of the NHS is underpinned by four main policies: The Health of the Nation, Community Care (Caring for People), The Patient's Charter and a Primary Care Led NHS. Provision for the objectives in this chapter appears in the 1996-97 Main Estimate for Class XI, Vote 1.

National Health Service Executive

4.3 The NHS Executive is the headquarters of the NHS within the Department of Health. It advises Ministers on the development of policy on health care and is responsible for the implementation of that policy and for the effective management of the NHS, with the aim of enabling the NHS to fulfil its purpose. It does this by:

- setting a strategic framework for the NHS;
- securing and allocating resources for the NHS and ensuring value for money;
- improving the knowledge base of the NHS; and
- management of the NHS and development of the NHS internal market.

4.4 This chapter presents information on the NHS under the following headings:

Management and Resources

The structure of the NHS

HCHS resources and their allocation

HCHS capital: the estate and its financing

HCHS staffing

FHS resources and staffing

Baseline performance

HCHS activity, efficiency and unit costs

quality and outcomes

performance on Patient's Charter standards

financial performance of health authorities and trusts

other Value for Money developments

FHS performance in each service area

Future Plans

Priorities for further development in 1996-97

Management and resources

Structure of the NHS

4.5 The structure of the NHS reflects the introduction of the internal market in 1991, and the subsequent streamlining of central management. District health authorities were given responsibility for purchasing hospital and community health services for their local populations, while the GP fundholding scheme created opportunities for GPs to take direct responsibility for purchasing services for their patients. NHS trusts provide the services that DHAs and fundholders wish to secure.

4.6 However, it is important to remember that the Family Health Services form most people's first point of contact with the NHS. They provide most of the day to day health care needed by the community. For example, there are about 250 million consultations a year with family doctors. Those who visit their family doctor, dentist, community pharmacist or optometrist expect to receive high quality care and advice. Increasingly this includes health promotion advice to encourage healthy lifestyles. The role of FHS contractors, particularly GPs, in identifying patients who need more specialised investigation or care and making appropriate referrals is also a major factor in the effective functioning of the secondary care services. The last decade has seen continued growth and development in the Family Health Services in line with the Government's policy to build up primary care services.

Managing the new NHS

4.7 The Health Authorities Act 1995 received Royal Assent on 28 June 1995. On 1 April 1996, the Act:

- abolishes regional health authorities (RHAs) and creates a single structure (the NHS Executive - comprising a headquarters and eight regional offices) for central management; and
- requires district health authorities (DHAs) and family health services authorities (FHSAs) to merge to form single new health authorities.

4.8 These changes build on the NHS reforms and continue the devolution of responsibilities and decision-making in the NHS to local level. By 1997-98, total annual savings from the abolition of RHAs and the creation of single new Health Authorities at local level are expected to be around £150 million. These savings will be retained by the NHS and available for patient care.

Merged Health Authorities

A clearer role for Health Authorities

4.9 The new health authorities which will come into existence from 1 April 1996 will develop a local health strategy to meet national and local priorities in collaboration with GPs, NHS trusts, local people and other agencies. They will play a key role in supporting GPs in their capacity as providers of health care and enabling GPs to take on purchasing responsibilities. In addition, they will act as the focus for all local public health responsibility, ensuring that GPs, local authorities and NHS Trusts have access to, and are supported in their use of, public health advice.

NHS Trusts

4.10 At 1 April 1995 there were 433 operational trusts, about 99 per cent of all provider units. They are providing stronger management for the NHS with the aim of ensuring that the extra resources committed to the health service are put towards improved patient care. Trusts have three core financial duties :

- to generate the required return (currently six percent) on relevant net assets;
- to break even on an income and expenditure basis taking one year with another; and
- to meet, or come within agreed limits of flexibility, the external financing limit set by the NHS Executive.

4.11 Trusts earn all their income through contracts to provide healthcare for health authorities, GP fundholders and the private sector. As well as their current costs, trusts plan to recover in prices a 6% return on their average net relevant assets and depreciation (capital charges). The requirement on an individual trust to borrow or repay debt and build up investment is controlled by the external financing limit (EFL) issued to each trust by the NHS Executive. The EFL represents the difference between a trust's internally generated resources, its retained surplus and depreciation and its approved capital spend. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of the debt principal with any excess being invested.

4.12 NHS trusts are financially accountable and there are three main accountability tools; each trust must produce an annual business plan which covers the three forward years. They must also publish an annual report on the previous year's performance and the audited accounts for that year. There is also a general requirement on trusts to ensure that their activities are carried out in such a way as to achieve best value for money.

Responsibilities within the NHS

4.13 This overall framework for the NHS ensures that:

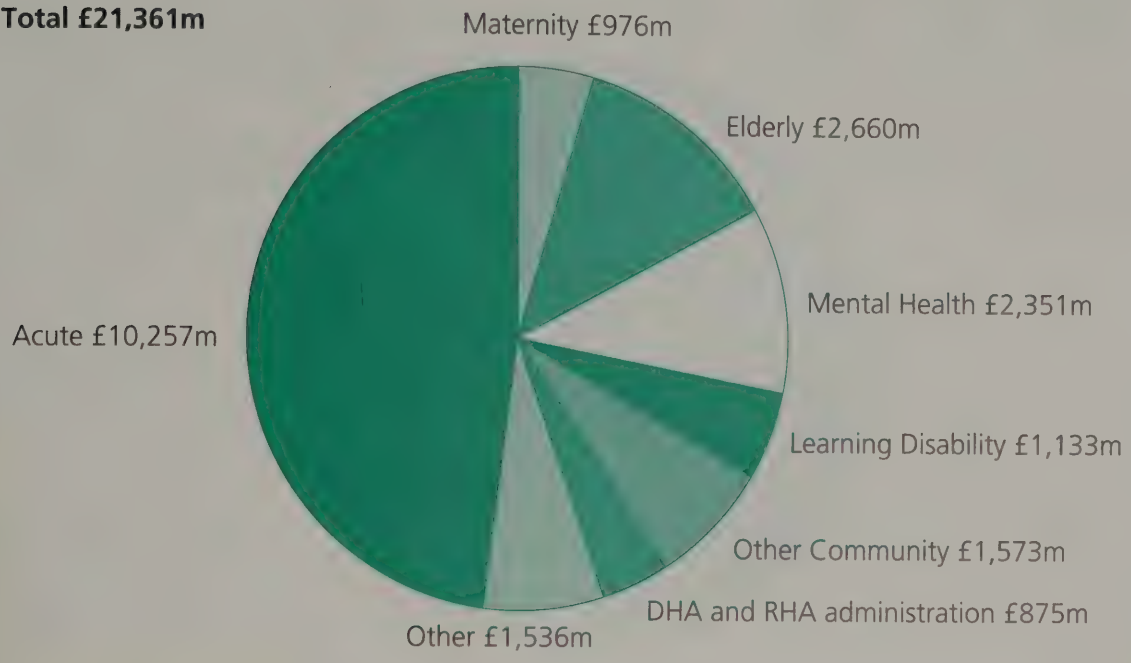
- Ministers, advised by the Department of Health, set out a framework of national priorities and targets for improvement. This is done through annual Priorities and Planning Guidance to the NHS and through important policies such as Health of the Nation White Paper and the Patient's Charter;
- Health authorities and GP fundholders assess the needs of the people they serve and decide what treatments and services are required to meet those needs. This process should be informed by proper consultation with the public;
- Individual clinicians decide the most clinically appropriate treatment and clinical priority for each patient, based on their assessment of that patient's needs.

HCHS Current Expenditure

4.14 **By Service Sector** **Figure 7** shows the breakdown by service sector of health authority gross current expenditure on the Hospital and Community Health Services in 1993-94, the latest year for which disaggregated data are currently available.

4.15 The figures include capital charges but do not include spending on GMS cash limited and other related services. For these reasons the total differs from figures shown in table 3.

Figure 7 - Hospital and Community Health Services Gross Current Expenditure by Sector 1993-94



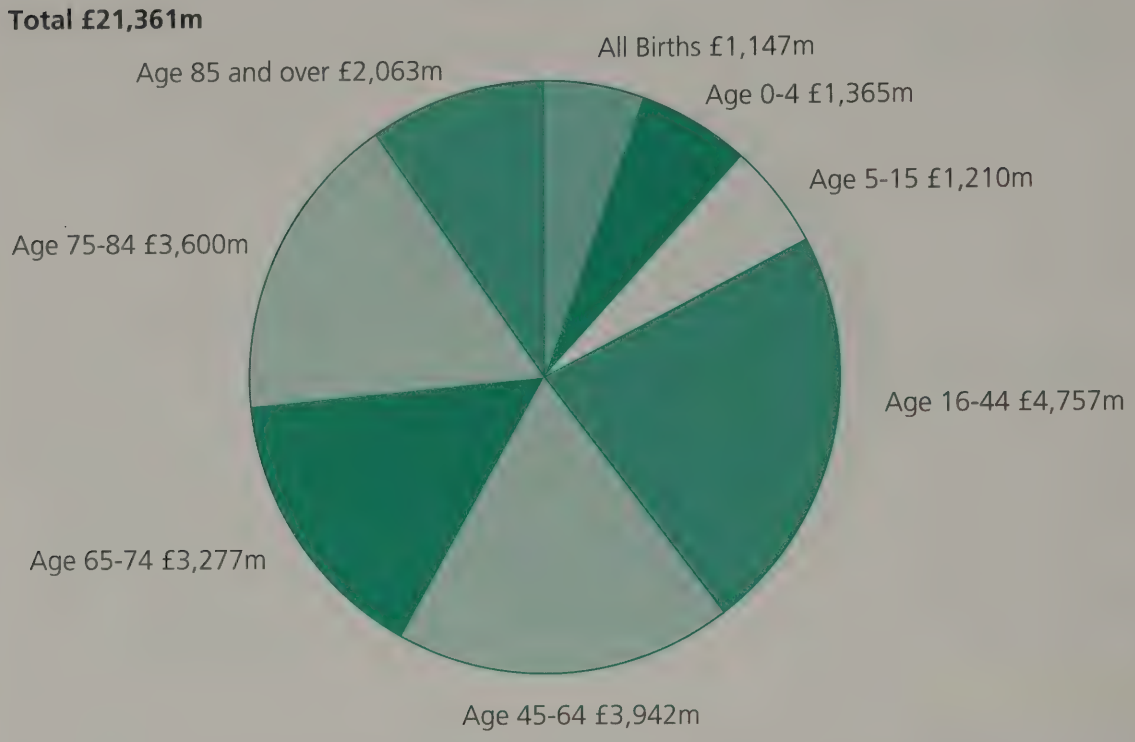
- Acute hospital services accounted for 48 per cent of the total, including £977 million spending by GP fundholders.
- Mental illness and learning disability services accounted for around 16 per cent, just over a seventh of which was spending on community services.
- Services specifically or mainly for elderly people - that is, geriatric inpatient and outpatient services, day care, chiropody services and district nursing services - accounted for 12 per cent of total expenditure.

4.16 Total expenditure on the community health services accounted for £3,251 million in 1993-94, 15 per cent of total HCHS spending. This proportion has risen over the decade, reflecting changes in patterns of care; in 1983-84, only 9 per cent of HCHS expenditure was on the community health services.

4.17 The cost of regional health authorities and district health authorities in 1993-94 was £875 million, 4 per cent of all HCHS expenditure. The Government's proposals, described in paragraphs 4.7 to 4.8, for streamlining health authorities will lead to substantial savings in these costs.

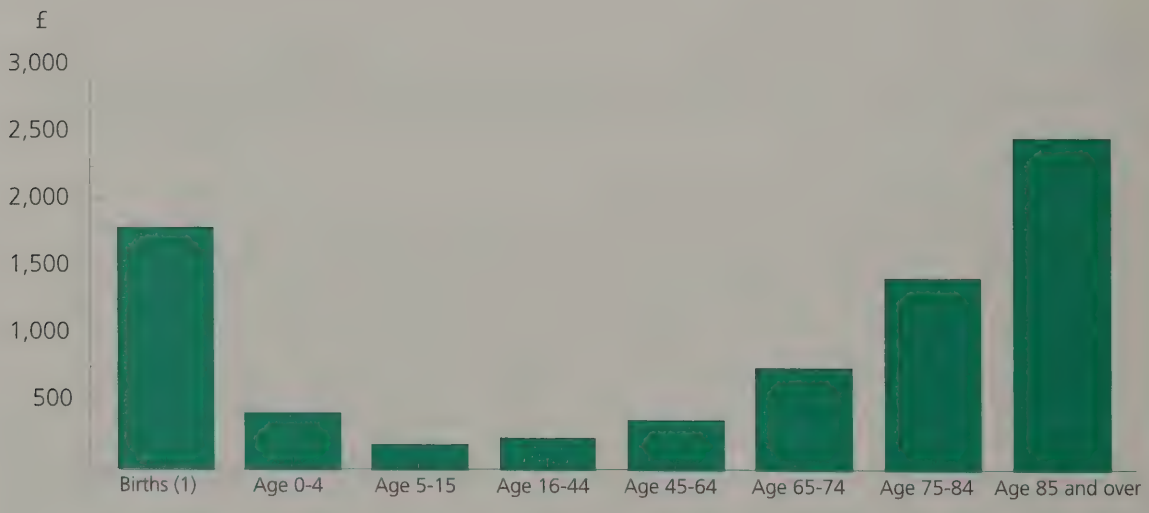
4.18 **By Age Group Figure 8** shows that while people aged 65 and over make up only 16 per cent of the population, they account for some 42 per cent of total HCHS spending. This is because over forty per cent of acute expenditure and significant proportions of expenditure on services for mentally ill people and on other community services are for those aged 65 and over.

Figure 8 - Hospital and Community Health Services Gross Current Expenditure by Age 1993-94 (estimate)



4.19 **Figure 9** shows the estimated expenditure on the HCHS for each age group, expressed as a cost per head of population. Expenditure per head rises with age after childhood, reflecting the greater use of health services by older people.

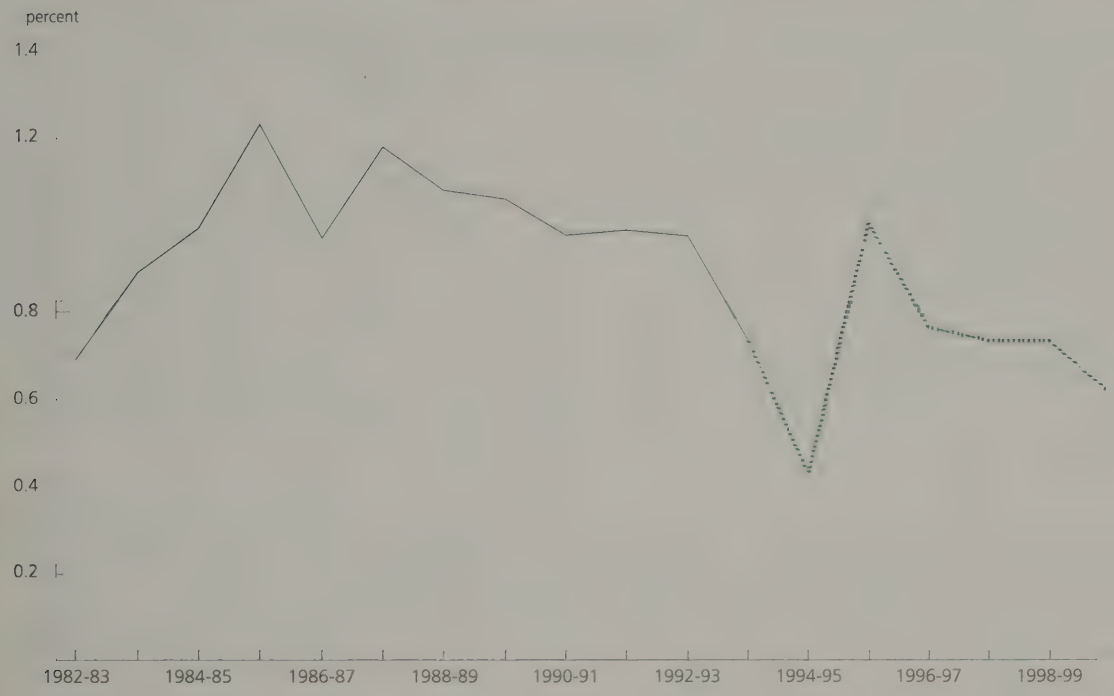
Figure 9 - Hospital and Community Health Services Gross Current Expenditure per Head 1993-94 (estimate)



(1) This figure is for all births, including still births

4.20 The increasing number of elderly people in the population therefore represents a continuing cost pressure on the HCHS. As **Figure 10** shows, the increase averaged around one per cent per year between 1983-84 and 1993-94. There is a steady decrease in demograhic pressure from the mid 1980's onwards; reducing to less than 0.7 per cent per year by the year 2000. The historical estimates are slightly different from those presented in last year's Report because revised population estimates, produced following the 1991 Census, have been used in the calculation.

Figure 10 - Estimated Growth in Demand for HCHS from Demographic Changes: Increases over Previous Year



Allocation of HCHS Resources

4.21 £23,182 million has been made available for HCHS current spending in 1996-97 (see table 3, HCHS net). In arriving at allocations to health authorities, a series of adjustments are made to this to reflect the post reforms financing of capital in the HCHS, and a number of services are financed by special arrangements: top sliced funding, national levies and special allocations. **Table 8** summarises the way in which national HCHS revenue translates into HA general allocations: paragraphs 4.22 to 4.27 give further details.

Table 8 - Distribution of 1996-97 HCHS Resources

	£million (1996-97 levels)	% increase
HCHS Revenue	23,181.50	1.11
Capital redefinition [1]	98.36	
Capital Charges	2,422.67	
Other adjustments	115.43	
Less top slicing	- 244.79	
Funding for HAs	**25,573.17**	**0.95**
Less national levies	-2,707.15	
HA allocations	**22,866.02**	**1.12**
Allocated as:		
Special Allocations	1,970.46	1.35
General Allocations	20,895.56	1.10

Note (1) This adjustment represents the difference between the capital threshold used in the NHS (£5,000) and that used by Central Government (£1,000).

Top Sliced Budgets

4.22 These budgets mainly fund statutory bodies such as the Special Hospitals and the Prescription Pricing Authority. Budgets over £10 million are shown in the **Table 9**.

Table 9 - 1996-97 Top Sliced Budgets (over £10m)

Budget	£million 1996-97 at 1995-96 levels
Special Hospitals	29
Prescription Pricing Authority	41
Community Health Councils	20
Dental Practice Board	20
All other budgets	27
Total (1995-96 prices)	**237**
Provision for uplift	7
Total (1996-97 prices)	**244**

National Levies

4.23 The abolition of RHAs has required new funding arrangements for a number of activities previously funded by regional top slicing or central budgets. This has taken the form of a national levy on all HAs, ie an amount deducted from their allocations.

4.24 Three major levies have been introduced in 1996-97 covering activities previously funded from regional health authorities' top-slicing:

- funding for postgraduate medical and dental education (MADEL)
- funding for non-medical education and training (NMET) - mainly nurses/midwives, PAMs and other professional groups
- research and development (R&D)

4.25 Figures are shown in **Table 10**.

Table 10 - 1996-97 Levies

£million

Budget	1996-97 at 1995-96 levels
Medical and dental education levy (MADEL)	503
Non-medical education and training (NMET)	771
Service increment for teaching (SIFT)[1]	445
Research and Development	424
COMMON SERVICES[2] - Budgets over £10m are as follows:	
Medical Negligence	77
London Implementation Group	75
Supra Regional Services	69
Distinction Awards	54
Purchase of Vaccines	39
Information Management Group	24
Overseas Patients	18
Junior Doctors Hours (part)	18
Injury Allowances	17
All Other Budgets	108
Common Services Total	499
Total (1995-96 prices)	2,642
Provision for uplift	65
Total (1996-97 prices)	2,707

Notes

(1) The Service Increment for Teaching meets the additional costs of supporting undergraduate medical and dental education.

(2) This levy funds budgets covering a wide range of activities from which health authorities benefit (e.g. Supra Regional Services, Injury Allowances and the National Poisons Information Service).

Special Allocations

4.26 These represent funds allocated to health authorities under special distributional arrangements reflecting relative need for the services concerned. These allocations totalled £1,970 million and included £895 million for spending by family doctors on practice staff (fundholding and non-fundholding), premises improvements and computing costs, and £270 million for AIDS and drug related services, **Table 11** gives details of the special allocations in 1996-97.

Table 11 - 1996-97 Special Allocations £ millions

Budget	1996-97 allocation at 1996-97 prices
Old Long Stay Patients [1]	615
General Medical Services (cash limited)	895
GP Out of Hours	39
AIDS - Treatment & Care	186
AIDS - Prevention	51
Drugs misuse services	33
Joint Finance	152
Total	**1,970**

Note

(1) Patients who were in hospitals for people with learning disabilities or mental illness hospitals in 1971. These count as residents of the host HA and not the HA where they resided prior to admission.

General Allocations

4.27 The remaining £20,896 million was distributed to health authorities as planned general allocations. This represents a real terms increase of 1.1 per cent. The distribution of this growth aimed to balance the need to make progress towards equalising the distribution of resources, and the need for continuity and stability. All health authorities, with the exception of the two most over target health authorities, have received a minimum real terms increase 0.5 per cent. In addition, health authorities under their weighted capitation target have received a share of the balance of the 1.1 per cent, with those most under target receiving the biggest increases (see **Figure 11**). Following these planned allocations the distribution of distances from target are shown in **Figure 12**. In 1996-97 considerable progress has therefore been made towards equalising the distribution of resources and more than 50 per cent of health authorities will be within +/- 2 per cent of their weighted capitation target.

Figure 11 - 1996-97 HCHS Planned General Allocations: Distribution of Growth

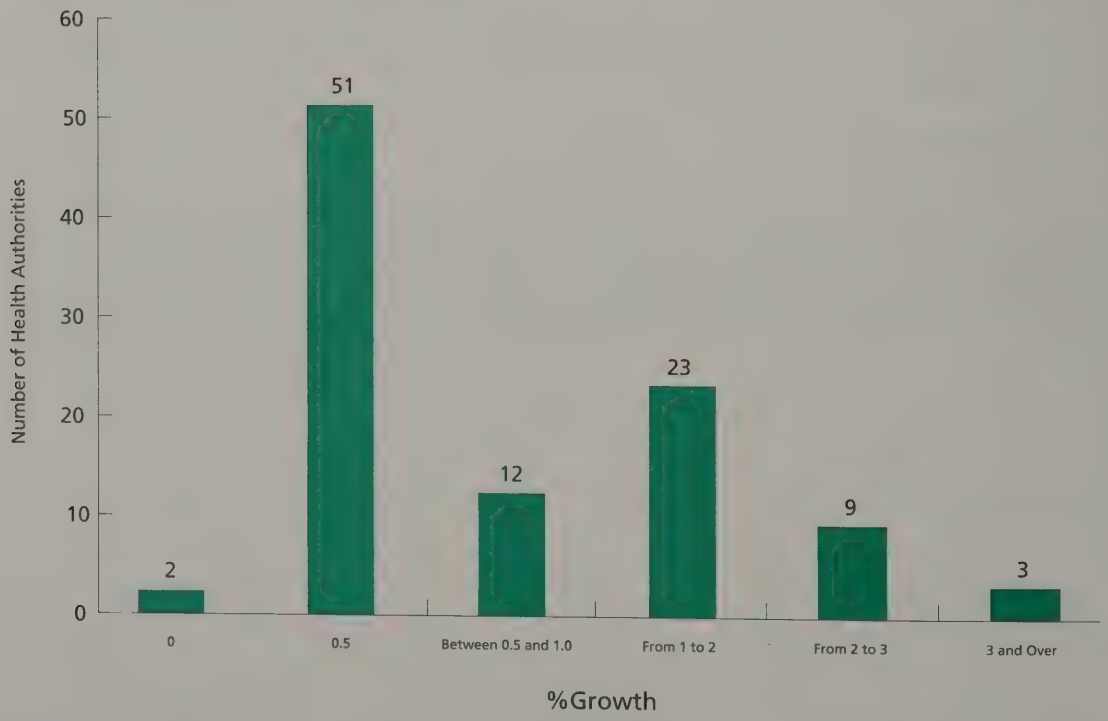


Figure 12 - Health Authorities Distance from Target (DFT) 1996-97

HCHS Capital

4.28 The value of the **NHS estate** was about £24 billion at April 1992, including about 1400 hospitals and many other healthcare premises on 16,500 hectares of land. The residential estate consisted of 12,000 houses and flats and 53,000 hostel places.

4.29 **Capital Building Programme** At the end of Sept 1995, there were 114 contracts, each worth over £1 million under construction, with an aggregate cost of £634 million. This includes 8 contracts worth £15 million or more at an aggregate cost of £249 million representing 39 per cent of all contracts in excess of £1 million.

4.30 It is anticipated that £1.2 billion will be spent in 1995-96 on constructing, improving and modernising NHS buildings.

- Over 700 schemes each costing over £1 million have been completed in the last 10 years.
- About 70 schemes each costing over £1 million are due to be completed in 1995-96.
- About 100 schemes have been approved with expenditure programmed in 1995-96 and 1996-97.

Private Finance Initiative

4.31 The Private Finance Initiative is proving to be very suitable for NHS projects, and is helping to sustain the NHS capital programme at historically high levels. In the coming years it is expected that PFI will make a substantial contribution to NHS capital needs. The PFI is about modern and efficient facilities for the delivery of health care, with the private sector providing and managing the risks in a wide range of facilities for the NHS. Exploration of private finance options is a standard part of option appraisal for capital investment within the NHS.

4.32 Partnerships with the private sector make available to the NHS additional resources of skill and expertise, access to new sources of capital and opportunities to share risk and benefit from economies of scale. Private finance improves the cost-effectiveness of a capital project for the NHS by; achieving economies of scale through asset sharing, increasing operational efficiency through the use of private sector expertise, and generating new sources of income from outside the NHS and through the use of short leases through which other users can re-use assets. PFI reduces the risks associated with capital projects for the NHS. Such risks include delays in construction, cost overruns, costs of latent defects and unavailability of facilities, higher than foreseen maintenance and repair costs, and failure of income generation projects to fulfill projections.

4.33 PFI puts risks with the party best able to manage them. This adds value for the taxpayer and patients through the cost effective development of modern healthcare facilities. Under PFI, the focus on NHS needs, outcomes rather than inputs, the cost effective allocation of risk , and the integration of service operation with design and construction elements combine to improve value for money compared to conventional public procurement.

4.34 Since the launch of PFI, 47 NHS schemes with a capital value of £1 million or over have been approved. The total value of these schemes amounts to about £225 million. Many more schemes have been approved locally. Procurement is underway for around 40 major schemes, costing in total over £1.5 billion, for a new generation of NHS hospitals designed, built and maintained by private sector consortia. The Department expects to approve a number of these schemes over the next year. Schemes already announced include a £20 million scheme at the Royal Berkshire and Battle NHS Trust, the re-development of South Buckinghamshire NHS Trust hospitals at High Wycombe and Amersham worth £35 million, and a £50 million scheme, which includes a paediatric wing, at St James's and Seacroft University Hospitals NHS Trust in Leeds. The substantial number of acute PFI schemes within the procurement process together with the potential for PFI in primary and community settings implies that extra capital will be introduced across the NHS in the future.

4.35 PFI re-inforces the principle of health care based on clinical need without regard to the ability to pay. It delivers a modern and efficient service, while freeing up the NHS to make clinical decisions for patients. PFI schemes must have the full support of local health commissions and other purchasers of clinical services. Each private finance project is assessed on its merits. The two main criteria of value for money and risk transfer are thoroughly examined in each scheme, giving assurance that private finance is more cost-effective than public finance over the useful life of the asset. Also, schemes must be judged by purchasers to be affordable. Together, the disciplines of the internal market, the guidance in the Capital Investment Manual, and the need to test for private finance, ensure that NHS trusts take a rigorous approach to capital investment.

4.36 The Private Finance Unit of the NHS Executive has been strengthened in 1995 to provide additional support, particularly to trusts undergoing major capital projects. In 1995 the Unit has co-ordinated and produced guidance on the use, appraisal, evaluation and monitoring of private finance in NHS capital investments. The Unit has issued guidance both on mainstream capital investments and on information management and technology schemes. The Unit has also run a series of PFI training courses for NHS Executive regional offices. In addition, a comprehensive manual setting out the process of structuring a major PFI project is being prepared.

4.37 In the course of the year, Unit staff have addressed a large number of conferences and seminars on private finance. As knowledge has built up in the NHS and the private sector these conferences focus increasingly on detailed issues, rather than general principles. The NHS Executive is also developing the NHS Capital Investment Database which will record details of large capital investments, whether publicly or privately funded.

HCHS Staffing

4.38 The NHS is one of the largest employers in the world. In September 1994, staff in post in England (excluding FHS contractors) totalled 763,000 whole-time equivalents. Staff costs account for almost two-thirds of total NHS expenditure. **Table 12** shows how the numbers of staff in post for each of the main HCHS staff groups in England have changed since 1984. Some of the main features of change are:

- the numbers of whole time equivalent (wte) HCHS medical and dental staff increased by 21 per cent between September 1984 and September 1994. On average, wte hospital medical consultants grew by 2.5 per cent a year, and wte junior doctors by 1.8 per cent a year during this period. (All calculations are made on figures excluding locums)

- numbers of wte professional and technical staff increased by 28 per cent.

- general and senior managers did not exist as a separate staff group before 1986. The subsequent increase in numbers is largely due to the reclassification of staff from professional and administrative groups (including many senior nurses) as managers; approximately 65 per cent of the increase between 1993 and 1994 in particular is the result of such reclassification. The remainder reflects the deliberate strengthening of the management of corporate functions and clinical support, and the devolution of work to local level. General and senior managers account for only 3 per cent of the total NHS workforce and 4.4 per cent of total NHS expenditure on salaries and wages.

- the number of administrative and clerical staff increased in recent years up until 1992, reflected both the strengthening of functions such as information technology and personnel together with increased support to clinical services, Figures over the last two years have fluctuated showing a net drop from 135,010 (1992) to 134,610 (1994). Over a quarter of administrative staff work in direct support to clinicians (for example, as ward clerks, in medical records and as medical secretarial staff) so allowing them to concentrate their skills and experience on direct patient care.

- nursing and midwifery staff numbers decreased by 11 per cent since 1984. Traditional training of nurses is being replaced by Project 2000 training. Project 2000 students are considered as supernumerary and are not included in workforce numbers. By contrast, traditional learners are counted as part of the workforce. This change masks an underlying trend of an increase of 5 per cent in the number of qualified nursing and midwifery staff since 1984.

- the sharp falls throughout the period in the numbers of directly employed ancillary staff and of maintenance and works staff reflect the continuing effect of competitive tendering exercises.

Table 12 - NHS Hospital & Community Health Services (HCHS) Staff by Main Staff Groups England as at 30 September each year

whole time equivalents and percentages

Staff Group	1984	1989	1993	1994	percentage change 1984-94
Nursing & Midwifery (including agency)[1]	397,500	405,800	366,200	353,100	-11.2
% of all staff	48.6	50.0	47.3	46.3	
Medical & Dental (including locum)[2]	42,400[3]	46,300	51,100	52,200	
% of all staff	5.2	5.8	6.6	6.8	
All Professional & Technical (excluding works)	72,700	81,400	91,100	92,800	27.7
% of all staff	8.9	10.2	11.8	12.2	
Ancillary	152,200	102,400	77,800	72,800	-52.2
% of all staff	18.6	12.9	10.0	9.5	
Administration & Clerical	110,300	116,800	132,600	134,600	22.0
% of all staff	13.5	14.7	17.1	17.6	
Maintenance & Works	26,200	21,200	16,700	15,200	-42.1
% of all staff	3.2	2.7	2.2	2.0	
General/Senior Managers	-	4,600	20,000	23,000	.
% of all staff	.	0.6	2.6	3.0	
Ambulance (including Officers)	18,100	18,900	17,500	17,900	-0.9
% of all staff	2.2	2.4	2.3	2.4	
Others	-	-	800	1,400	.
% of all staff	.	.	0.1	0.2	
Total employed staff	819,400	797,300	773,900	763,000	-6.9

Source: Department of Health Medical & Dental and NonMedical Workforce Censuses

Notes:
1. Nursing and midwifery figures for 1993 and 1994 exclude students on Project 2000 training courses (there were around 28,000 Project 2000 students in September 1993 and 32,000 in September 1994

2. Medical and Dental figures includes all permanent paid and honorary staff in hospitals and community health services, hospital practitioners and parttime medical /dental officers.

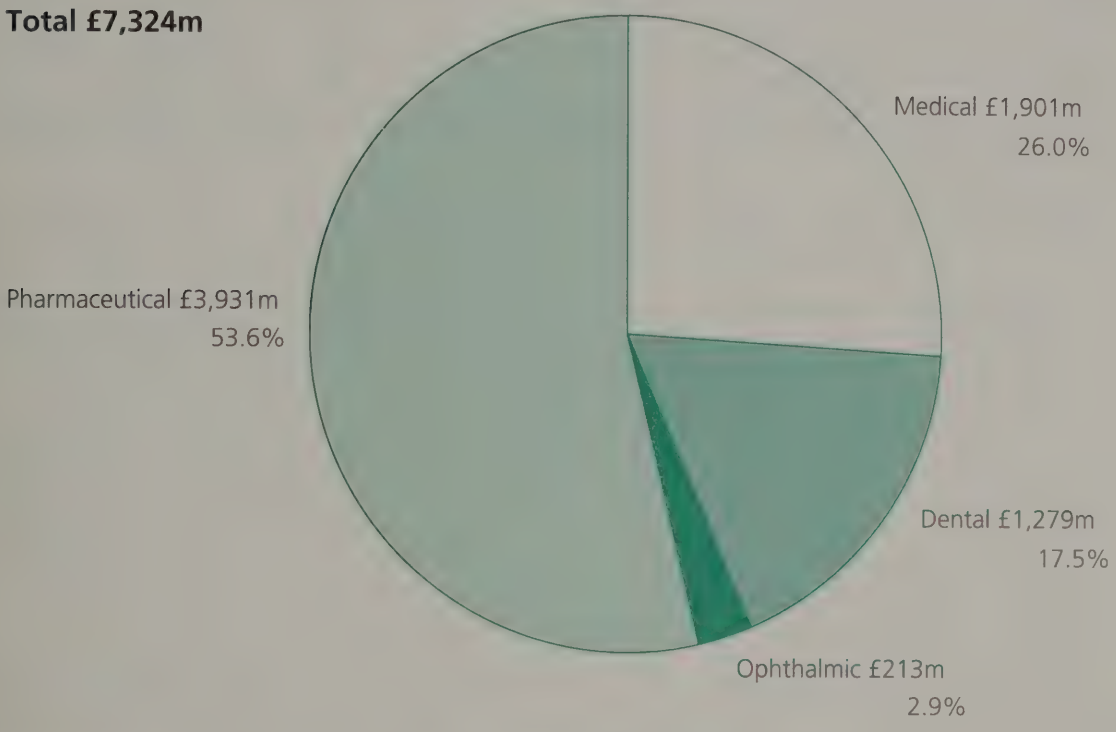
3. Figures for 1984 locum medical and dental staff exclude most, if not all, agency locums. For this reason, percentage changes between 1984 and 1994 cannot be calculated for these staff.

Census data is collected at 30 September each year. It includes staff at the Dental Practice Board, Prescription Pricing Authority, Special Health Authorities and Family Health Service Authorities. For 1989, 1993 and 1994, figures also include the Other Statutory Authorities (eg PHLS and HEA) not previously collected in the Annual Workforce Censuses. Figures are therefore not comparable with those from earlier years. All figures are also independently rounded to the nearest 100 whole-time equivalents. Percentages are calculated on unrounded figures. '__' denotes zero and '.' denotes not applicable. Independent figures exclude independent family health service contractors and practice staff directly employed by them.

FHS Expenditure

4.39 Gross expenditure on all elements of FHS (including spending by GP fundholders on drugs) amounted to £7.3 billion in 1994-95, of which 9.2 per cent was met from prescription and dental charges paid by patients. **Figure 13** shows how gross expenditure is distributed among the constituent services.

Figure 13 - Non cash limited FHS gross expenditure 1994-95



Footnote: Excludes some items of miscellaneous expenditure and therefore figures do not sum to totals in table 3
Pharmaceutical expenditure includes cash limited spending on GP fundholding drugs

4.40 In the ten year period between 1984-85 and 1994-95, gross expenditure on the non cash limited Family Health Services increased by 34 per cent in real terms. The main changes in spending over this period were:

General Medical Services (GMS): total GMS expenditure (including cash limited and non cash limited spending) has increased by 76 per cent in real terms. The number of General Medical Practitioners (GMPs) has increased by 12 per cent and gross expenditure per GP has increased by 45 per cent in real terms (see Table 19). Since the introduction of the new GP contract in 1990-91 expenditure on certain directly reimbursed expenses - computing and staff reimbursements and some premises costs together with GP fundholders' management allowances (PFMA) and computing costs - has been cash limited. By 1994-95 cash limited reimbursements represented 32 per cent of total GMS expenditure and had grown by 21 per cent in real terms since 1991-92 (or by 14 per cent excluding PFMA). (see **Table 13**). This compares with a 9 per cent real increase in non cash limited expenditure since 1991-92.

Table 13 - GMS Cash Limited Expenditure

£million

	1991-92	1992-93 (1)	1993-94	1994-95	1995-96 allocation
Staff	418	482	514	}	}
Premises Improvements	126	134	116	} 698	} 711
Computers to support GMS	22	22	20	}	}
PFMA	14	29	49	66	108 (2)
Computers to support GP fundholding	12	18	19	20	25
TOTAL	592	685	718	784	844
Year on Year Real terms increase (%)	20.9	11.2	1.8	7.1	4.8

1. From 1992-93 regional expenditure on practice staff, premises improvements and computers was allocated and accounted for as one amount.

2. Includes IT running costs incurred by full fundholders, previously allocated as part of computing support.

Pharmaceutical Services (PhS): an increase of 55 per cent in real terms. The PhS consists of the "drugs bill" and the cost of dispensing prescriptions. The drugs bill, the largest component of the pharmaceutical services, amounted to £3.23 billion in 1994-95. In real terms, it has grown by almost 66 per cent over the period. The proportion of gross costs met from prescription charges (including receipts from the sales of prescription prepayment certificates) has fallen from 7.8 per cent to 7.3 per cent and the Government's net expenditure has risen by nearly 56 per cent in real terms. In 1994-95 nearly 468 million prescriptions were dispensed, almost 36 per cent more than in 1984-85. The cost of dispensing prescriptions (fees paid to pharmacists, dispensing doctors and appliance contractors) was £686 million which represents an increase of 17 per cent in real terms over 1984-85. The costs per prescription dispensed are set out in Table 20.

General Dental Services (GDS): an increase of 22 per cent in real terms. The proportion of gross costs met from patient charges has increased from 27 per cent to 30 per cent. The Government's net expenditure has increased by 17 per cent in real terms.

General Ophthalmic Services (GOS): a decrease of 25 per cent in real terms over the period as a whole (see paragraph 4.118 for further details). This reflects the fact that, from 1 April 1989, eligibility for free NHS sight tests has been available only to certain groups, namely all children, students aged under 19 in full time education and adults entitled to full help from the NHS Low Income Scheme or with special medical needs.

FHS Staffing

4.41 GP numbers grew by almost 1.1 per cent over the year to October 1994, compared with an annual average growth rate of 1.2 per cent in the years since 1984-85. These figures do not however take into account the fact that an increasing proportion of GPs are part timers. The number of community pharmacies in contract with an FHSA has remained broadly stable since entry controls were introduced in 1987 and stood at 9,771 in March 1995. The number of general dental practitioners has grown by nearly 13 per cent since 1984-85, whilst the number of ophthalmic practitioners in contract to carry out NHS sight tests has increased by nearly 14 per cent in the same period.

Table 14 Family Health Services - Staffing

Numbers and percentages

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95	% change 1993-94 to 1994-95
Number of general dental practioners (GDPs) [1]	14,070	15,480	15,450	15,410	15,770	15,890	12.9	0.7
Number of opticians [2]	5,830	6,430	6,500	6,600	6.620	6,620	13.7	0.0
Number of general medical practitioners [3]	23,640	25,620	25,690	25,970	26,290	26,570	12.4	1.1
Number of contracting pharmacies [4]	9,210	9,760	9,760	9,760	9,770	9,770	6.1	0.1

(1) Principals, assistants and vocational trainees at 30 September.
(2) Optometrists and ophthalmic medical practitioners at 31 December.
(3) Unrestricted principals at 1 October.
(4) Excludes appliance contractors and dispensing doctors. From 1991-92 figures are shown as at 31 March each year. Figures for earlier years refer to 31 December.

Baseline performance

Introduction

4.42 Each year the NHS Executive issues Priorities and Planning Guidance for the NHS. This sets out the strategic direction for the service, identifies the range of "baseline requirements" which all health authorities are expected to deliver, and also identifies a limited range of national "medium term" priorities: areas in which the NHS needs to make significant progress over the next 3-5 years. Health authorities are expected to take full account of these requirements in developing their corporate contracts for agreement with the NHS Executive through its regional offices. Corporate contracts, supported by quantified plans known as the Common Information Core, set out how each health authority intends to deliver on national and local priorities, including baseline requirements, and where it intends to place its management effort.

4.43 Health authorities provide quarterly information setting out progress against their quantified plans, and also provide data in other key areas such as waiting times and the Patient's Charter. This information is used by the NHS Executive for in-year monitoring. The NHS Executive's regional offices have the key role in monitoring and reviewing the performance of individual health authorities and trusts while increasingly NHS Executive HQ is concerned with the overall national picture and with identifying and reporting the spread of performance at health authority level.

4.44 Paragraphs 4.46 to 4.116 below report on recent performance in delivering the baseline agenda, including agreed financial and activity targets and guarantees; Patient's Charter standards and guarantees; progress towards the Health of the Nation Targets (but also chapter 3, paras 3.14 to 3.32); and control of drugs expenditure; Paragraphs 4.117 to 4.220 below set out future plans for addressing the priorities for improvement.

Purchaser and provider based data

4.45 In line with the principles set out in paragraph 4.43 performance management is increasingly supported by data relating to health authorities who, with GP fundholders, "purchase" care for their populations. However, purchaser-based data have only been available since 1991-92, and in some areas data flows are still developing. The statistics included in this section therefore follow the practice of previous Departmental Reports by reporting on performance in terms of activity "provided" by NHS trusts and directly managed units. Annex F describes the difference in coverage of the two sets of data, and gives summary statistics based on "purchaser" data. Future Departmental Reports will give greater prominence to such statistics as information systems develop.

Hospital and community health services - performance

Activity trends

4.46 **Table 15** gives details of hospital activity levels for each of the main sectors based on information collected directly from NHS hospitals and other health care providers.

Table 15 Health service activity

'000s, days and percentages

	1984	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95 (thousands)	Annual average % change 1984 to 1994-95	% change 1993-94 to 1994-95
Ordinary admissions									
General and acute	5,246	5,677	5,685	5,913	5,987	6,127	6,210	1.7	1.4
Geriatric	344	447	468	508	527	554	548	4.6	-1.1
Maternity	869	968	990	1,010	1,015	1,056	1,059	1.9	0.3
All specialties	6,867	7,477	7,524	7,755	7,828	7,988	8,065	1.6	1.0
Day cases									
General and acute	872	1,152	1,251	1,535	1,785	2,080	2,439	10.5	17.2
All specialties	903	1,163	1,261	1,547	1,808	2,106	2,474	10.3	17.5
All finished consultant episodes									
General and acute	6,118	6,829	6,936	7,448	7,772	8,207	8,649	3.4	5.4
All specialities	7,770	8,639	8,785	9,302	9,635	10,094	10,539	3.0	4.4
New outpatients (referral attendances)									
New outpatients	8,508	8,519	8,502	8,942	9,342	9,683	10,363	1.9	7.0
General and acute	7,577	7,621	7,593	8,036	8,488	8,832	9,513	2.2	7.7
Geriatric	51	60	72	70	77	83	94	6.2	12.3
Maternity	731	689	695	684	612	600	588	-2.1	-2.1
Mental health	198	207	211	218	238	245	257	2.6	4.8
Learning disabilities	3	3	3	3	4	5	5	6.1	-10.9
New A & E (first attenders)	10,213	11,207	11,204	11,035	10,993	11,365	11,943	1.5	5.1
Ward attenders	n/a	900	981	1,008	1,029	985	980	-	-0.6
Occupied bed days								1984 to 1993-94	1992-93 to 1993-94
Mental health	24,700	20,800	19,300	17,100	15,400	13,900	-	-6.0	-9.7
Learning disabilities	14,300	9,100	8,600	7,600	6,500	5,500	-	-9.8	-15.4
Average length of episode (ordinary admissions) days								1984 to 1993-94	1992-93 to 1993-94
General and acute	10.6	8.3	8.0	7.4	7.0	6.7	-	-4.4	-4.3
Geriatrics	53.3	35.9	32.1	26.4	23.3	20.8	-	-8.8	-10.8

(1) The figures for 1984 are estimates of finished consultant episodes based on 1984 discharges and deaths adjusted using 1988-89 data where information was collected using both methods.
(2) Excluding well babies.
(3) Obstetrics and GP maternity
(4) From April 1992 patients seen by medical staff on a ward are recorded as outpatients rather than ward attenders.
(5) Figures from 1988-89 onwards are estimated based on data obtained directly from Regions.

- Between 1984 and 1994-95, the number of general and acute ordinary admissions and day cases grew by an average of 3.4 per cent a year.

- Within this increase there is a continuing shift towards treating patients on a day case basis. Since 1984, the number of day cases has grown to 2.4 million in 1994-95, 28 per cent of all general and acute episodes.

4.47 Statistics on activity in the community health and paramedical services over the period 1988-89 to 1993-94 collected from health care providers are reported in **Table 16**.

Table 16 - Community health and paramedical services activity statistics [1]

'000s of episodes [2][3][4]

1988-89	1989-90	1990-91	1991-92	1992-93	1993-94
Health visiting	4,100	3,900	3,600	3,700	3,700	3,700
Community nursing services (total)	2,800	2,800	2,600	2,700	2,800	2,800
District nursing	2,400	2,300	2,100	2,200	2,200	2,200
Community psychiatric nursing	230	240	250	270	300	340
Community learning disability nursing	20	20	20	20	20	20
Specialist care nursing	195	200	190	220	270	270
Chiropody services	880	920	910	940	970	1,010
Clinical psychology	150	150	140	150	160	170
Dietetics	650	630	620	640	640	670
Occupational therapy	770	750	740	840	880	940
Physiotherapy	3,100	3,200	3,200	3,300	3,400	3,500
Speech therapy	240	230	240	250	270	290
Community dental services [5]	n/a [6]	n/a [6]	1,160	1,190	1,210	1,160

(1) Owing to changes in definitions which occurred in 1988-89, it is not possible to provide comparative statistics prior to 1988-89.

(2) Number of new episodes commenced in the year except health visiting (number of different persons seen at least once in the year) and community dental services (number of episodes of care completed in the year.)

(3) Estimated national totals based on those districts supplying data.

(4) Data for 1988-89 to 1992-93 revised to take account of late and missing returns and correction of major errors.

(5) Includes a small number of discontinued episodes of care.

(6) Not collected on a comparable basis.

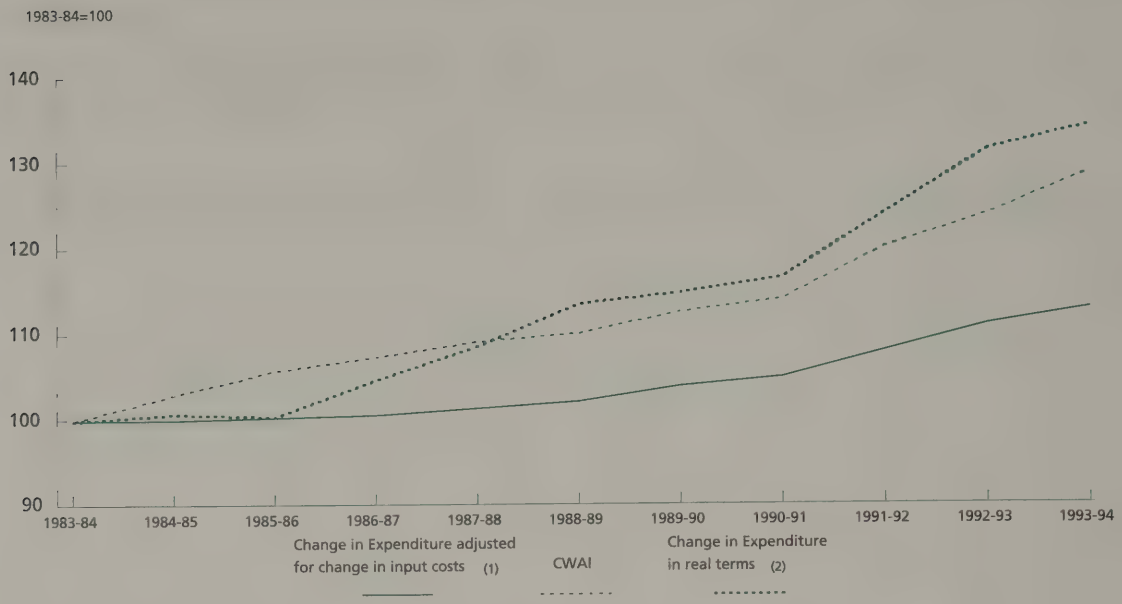
- Following a decline in the early part of the period, activity has remained broadly constant in some areas, whilst increasing in others.

- Since 1984-85 the number of practice nurses has increased by 370 per cent.

Aggregated activity

4.48 An overall measure of changes in HCHS activity is obtained by weighting together the activity increases in various areas of HCHS by the proportion of expenditure they receive (see **Figure 14**). This measure, the Cost Weighted Activity Index (CWAI), includes inpatient and day case episodes, outpatient and accident and emergency services. Community health services covered include immunisation, district nursing and ambulance services. The CWAI cannot monitor the full range of health service activities and there is some anecdotal evidence that improvements to and increases in the complexity of community health services are not fully reflected. To get a full picture of efficiency changes over time, the activity data in the CWAI are based on information supplied by hospitals and other health care providers (see annex F).

Figure 14 - HCHS cost weighted activity index



(1) That is, pay and price rises in the HCHS

(2) That is, adjusted for movements in output costs in the economy as a whole, as measured by GDP deflator. Output costs reflect not just input costs but also the efficiency with which inputs are used.

Efficiency and unit costs

4.49 A broad measure of the overall increase in the efficiency of the HCHS can be obtained by comparing increases in activity levels with increases in expenditure.

4.50 Figure 14 shows that overall activity levels have increased by 28 per cent between 1983-84 and 1993-94 (2.5 per cent per year on average).

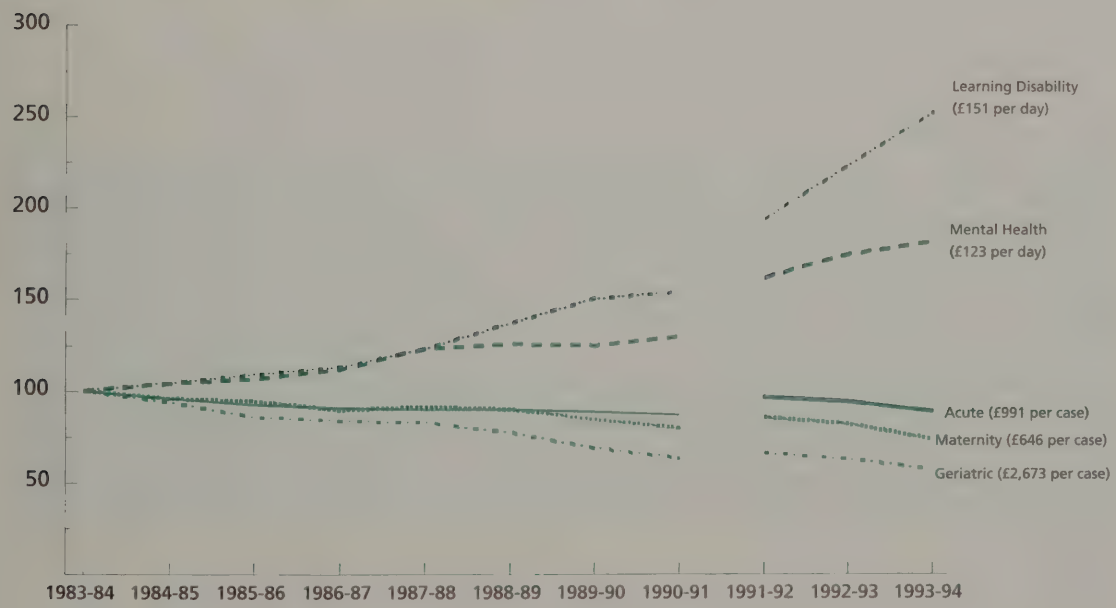
4.51 The total increase in activity of 28 per cent between 1983-84 and 1993-94 is much more than the increase in HCHS expenditure after allowing for changes in HCHS input costs, which over the same period increased by 13 per cent, as shown in figure 14. The implication is that efficiency has grown by 15 per cent over the period.

4.52 The CWAI based efficiency measure requires data from a number of sources; it is not available until after detailed data for the financial year have been analysed. Final estimates for the efficiency gain in 1994-95 are not yet available.

4.53 In-year, health authority efficiency is measured through the Purchasing Efficiency Index (PEI), produced on a different basis. The PEI suggests that the 1993-94 efficiency target of 2 per cent and the 2¼ per cent target for 1994-95 were achieved. Preliminary indications are that health authorities are on course to deliver their 3 per cent target for 1995-96. For 1996-97, it has again been possible to set a national efficiency target of 3 per cent, taking account of savings from reducing the costs of running health authorities and trusts management costs. This will be pursued through negotiation of individual targets with DHAs, making it possible to take better account of local progress and opportunities, setting realistic but challenging targets in each case.

4.54 **Hospital unit costs** **Figure 15** shows the trend in unit costs in the hospital sector since 1983-84 after allowing for movements in HCHS pay and prices. Costs per case in the acute, geriatric and maternity sectors have fallen over the period, largely because of declining lengths of stay. Following the 1991 NHS reforms, hospital and community units have completed a new form of accounts, for example including capital charges in financial returns from 1991-92. Because of this, figures from 1991-92 are not comparable with earlier years. There are also some doubts over the quality of financial returns data received from health authorities in that transitional year.

Figure 15 Average cost per inpatient or day case by hospital type 1983-84 to 1986-87; by specialty 1987-88 to 1993-94



Acute, geriatric and maternity sectors unit costs

- Between 1983-84 and 1990-91 the average cost of treating an acute patient declined by almost 13 per cent.

- The number of patients treated on a day case basis has increased by on average 10 per cent per year since 1983-84, while the length of stay for patients occupying a bed overnight has been cut by over a third to an estimated 4.3 days in 1993-94.

- The average cost of each geriatric case has declined by 37 per cent between 1983-84 and 1990-91, with length of stay falling by almost a half.

- The average cost of a maternity case declined by 20 per cent over the same period.

- Average costs for all these sectors have gone down between 1991-92 and 1993-94.

- Mental health and learning disability sectors.

- Average costs per day for mental health and learning disability inpatients rose by 31 per cent and 58 per cent respectively between 1983-84 and 1990-91 and by 13 per cent and 30 per cent respectively between 1991-92 and 1993-94.

4.55 However, the average dependency level of patients remaining in hospital in these sectors is, inevitably, higher than that of those discharged, and average unit costs tend to become higher as a result.

Measures of quality and outcomes

4.56 **Health outcomes** Adequate systems for the assessment of health outcomes - the benefits of particular health care or other interventions - are necessary for measuring achievement against objectives. One contribution to this, an initial range of Population Health Outcome Indicators, first published in 1993 as a consultation document, was based on currently available data (covering for example maternal and child health, general health and mental health). An updated and expanded version will, from 1995, be published annually as part of the Public Health Common Data Set. The validity and usefulness, as an aid to purchasing health care, of the initial range of indicators, is being piloted by health authorities. The results of this work should be available during 1996.

4.57 As a follow up exercise, the Department's Central Health Outcomes Unit (CHOU) is working to define the data needed to support an "ideal" set of indicators (some of which may require new data collection) for ten key health topics. A Population Health Outcome Model was developed to provide a framework for mapping the principal factors that can affect health outcomes at various stages and help to highlight areas where outcome indicators are needed. Working groups have now been formed to take this project forward. However, this is an incremental process and usable data will feed into the data set as and when they become available.

4.58 CHOU has also worked with clinicians to develop a set of clinical indicators and has commissioned the development of a set of Environmental Health Risk Indicators. During 1995, CHOU will attempt to bring the indicators in these various data sets together to create a single structured data set, which classifies indicators by health topic and outcome objective. This should allow a more systematic development of indicators in the future, targeted to fill essential gaps. CHOU also works with other divisions in the Department to commission a range of outcomes research and development projects, the results of which will feed into the creation of new and better indicators.

Acute sector developments

4.59 The Department has a range of initiatives to bring new knowledge on quality and cost-effective services to bear in the acute sector:

- in 1994-95, more than half of all elective operations were carried out as **day cases**, with all the therapeutic benefits that brings. Health authorities are expected to reach a target of 60 per cent of all elective surgery performed as day cases by 1997-98;

- thanks to a generous grant from the Wolfson Foundation, matched pound-for-pound by the Department of Health, two new state-of-the-art training centres for **minimal access surgery** were opened in 1995, one at Leeds General Infirmary and one in London at the Royal College of Surgeons;

- following a study published in February 1995, a professional working group has been set up to draw up guidelines on admissions to **intensive care** and **high dependency care**;

- in April 1995, the then Secretary of State launched a new strategic framework for the future development of **cancer services**. This aims to put the patient at the centre of care (see box);

Aims of the development of cancer services

Encourage greater public and professional awareness to help the early recognition of symptoms;

secure uniform access to high quality care to maximise cure rates and quality of life;

establish a network of specialised care comprising: better information to GPs to enable appropriate referrals and follow up; cancer units in local hospitals with expertise and facilities to treat commoner cancers; and specialist cancer centres in larger hospitals to treat less common cancers and support cancer units.

- a recent review of **ambulance response time standards** suggests the possibility of prioritising 999 calls so as to give the quickest response to callers with a condition (eg cardiac arrest) where evidence is that early intervention may increase the prospects of survival.

4.60 Better purchasing of more specialised services is also an objective. Following a review set up by the Chief Medical Officer into the purchase of **specialised services** the National Specialist Commissioning Advisory Group has been set up to advise the Secretary of State on the identification and funding of supra regional services, and other specialised services where there is a clinical and/or economic case for central purchasing; and commissioning purchasing guidelines;

Performance on Patient's Charter Standards

Patient's Charter

4.61 The Patient's Charter came into force on 1 April 1992 to improve the quality of health service delivery to patients as part of the Government's Citizen's Charter programme. The Patient's Charter sets out the rights of patients, and the standards of service they can expect to receive from the National Health Service. To ensure that the Patient's Charter is being delivered, the Department of Health regularly collects information on a number of key Charter standards. This shows that NHS performance on the majority of these standards has improved markedly over the year.

4.62 **HCHS standards** Performance against the immediate assessment in accident and emergency departments, and thirty minute wait in outpatients standards continued to improve. By the end of 1994-95, 93 per cent of patients were assessed within five minutes of arrival at accident and emergency and 88 per cent of patients were seen within thirty minutes of their appointment time in outpatient clinics.

4.63 This level of performance has been maintained or improved upon to date in 1995-96. See **Figures 16** and **17**.

Figure 16 - Performance against A&E standard: 1992-93 to 1995-96

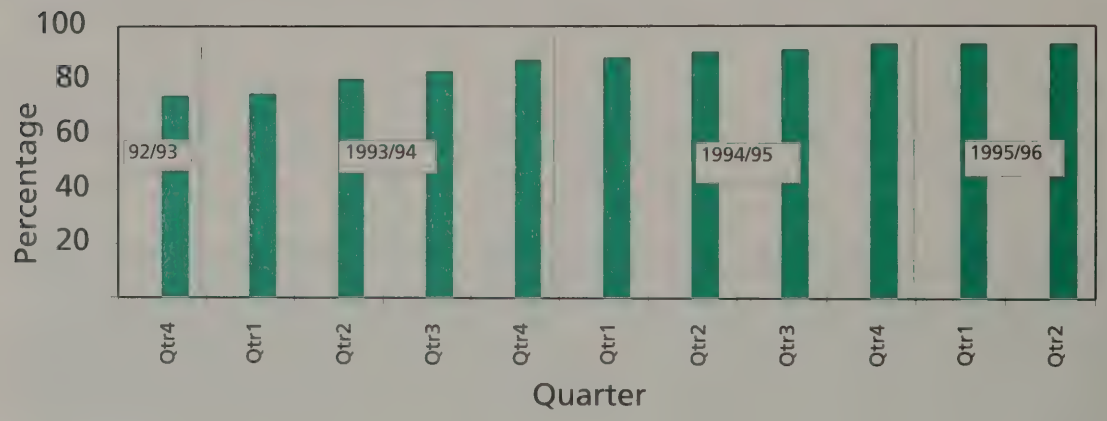
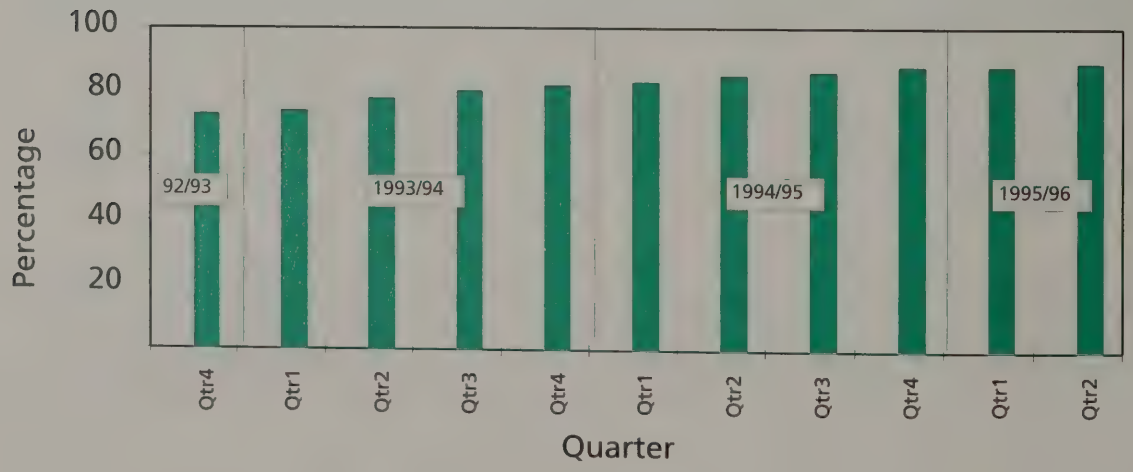
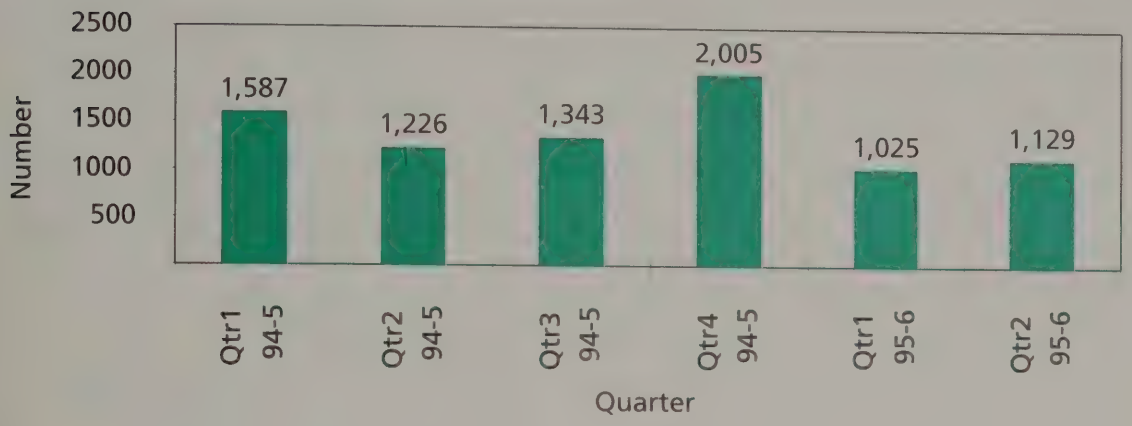


Figure 17 - Performance against outpatient standard: 1992-93 to 1995-96



4.64 The standard for cancelled operations was amended slightly for 1994-95; admission within one month was required after last minute cancellation rather than two months as before. Performance against this strengthened standard fluctuated throughout 1994-95, although the position in the early part of 1995-96 is improved. See **Figure 18**.

Figure 18- Performance against cancelled operations standard: 1994-95 and 1995-96



4.65 GP Practice Charters In April 1994 the then Secretary of State set a target that the Department should have 60 per cent of GP practices with charters by 31 March 1995. This target was exceeded, with 64 per cent of practices having charters and a further 8 per cent developing them on that date. By September 1995, 80 per cent of practices had or were developing charters.

Waiting times

4.66 Half of all admissions to hospital are immediate. The other half are elective, with a waiting time before the admission takes place. The median waiting time for elective admissions is six weeks with nearly three-quarters admitted within three months.

4.67 The NHS has been working to end the longest waits for treatment whilst ensuring that urgent cases continue to receive priority. Waits of two years or more for admission have now been ended and the Patient's Charter guarantee is that no one should now wait longer than eighteen months for admission. Progress is also being made on outpatient waits with a standard set that no one should wait longer than 26 weeks for an initial outpatient appointment, with 90 per cent of patients seen within 13 weeks.

4.68 **Inpatients and day cases** In March 1991 patients on the waiting list had waited an average of seven and a half months for treatment; by March 1995 the average waiting time had been reduced to four months. See **Figure 19**. During 1994-95 the total waiting list fell by 2 per cent, a reduction of around 21,000. This trend has proved difficult to maintain however with a 1 per cent increase during the first three quarters of 1995-96. The number of people waiting less than 12 months rose slightly during 1994-95 and this trend has continued into 1995-96. Progress continues to be made on reducing the numbers waiting long times for treatment. The number of people waiting over 12 months has been reduced sharply since the beginning of 1994-95 from 64,508 to 20,892 at 31 December 1995. The number of very long waiters has also been driven down. At the beginning of 1994-95 428 patients were waiting more than 2 years. Over the course of that year and the first three quarters of 1995-96 waits of more than 2 years have been eliminated and at 31 December 1995 only 3 patients were waiting more than 18 months. **See Figure 20**.

Figure 19 - Average waiting times: March 1991 to March 1995

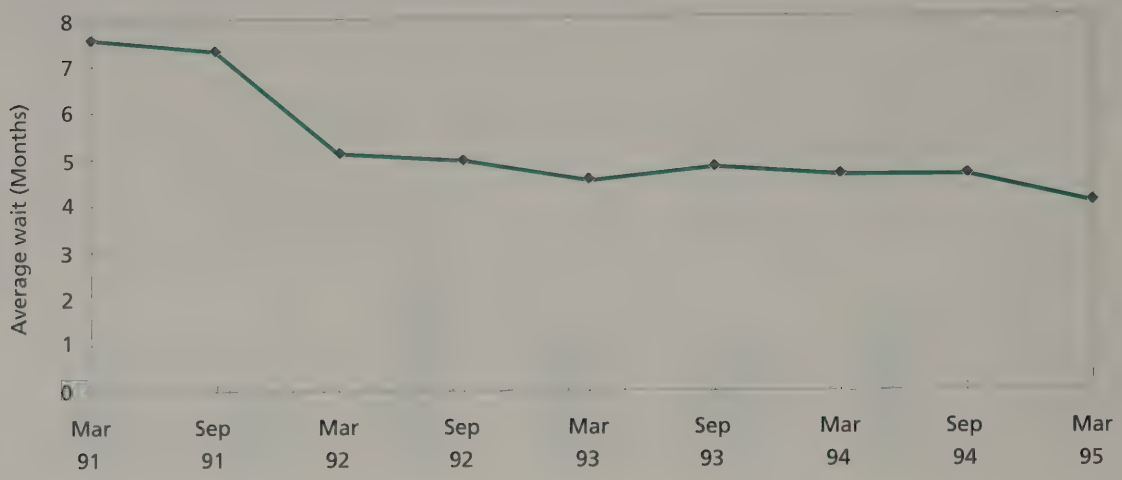


Figure 20 - England waiting list - size and by time band: 1991-1995

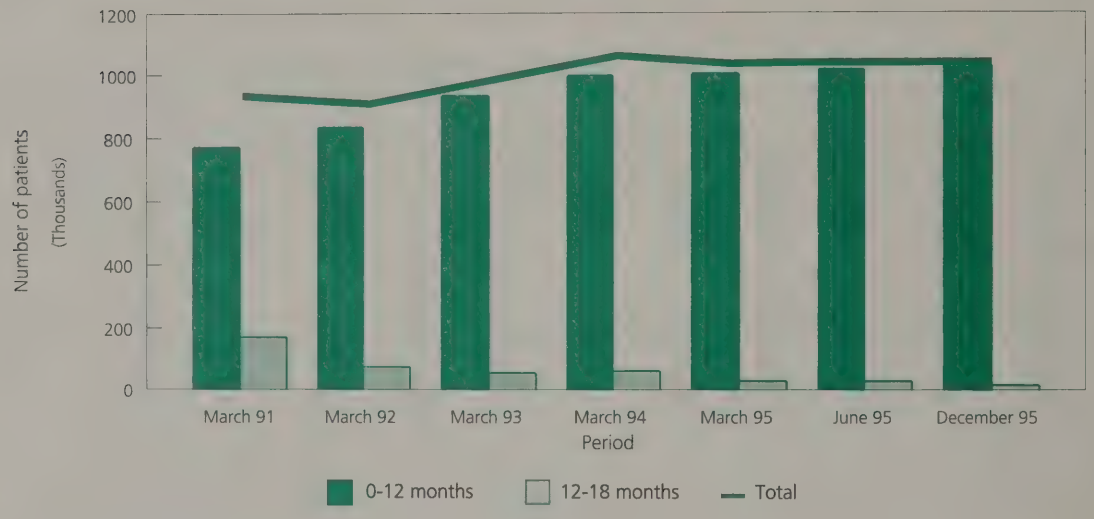
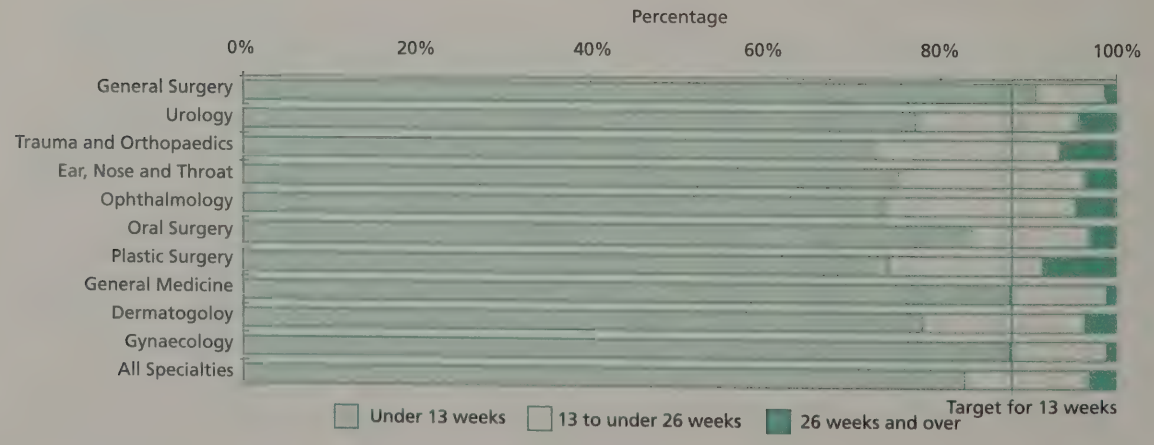


Figure 21 - Distribution of waiting time from GP referral to outpatient consultation by specialty: England, Quarter ended 30 September 1995



4.69 **Outpatients** Information on the time patients wait between referral by their GP and being seen in an outpatient clinic was first published in 1994-95. Figures for the quarter ended March 1995 show 95 per cent of first appointments seen within 26 weeks of referral and 82 per cent seen within 13 weeks. By the quarter ended September 1995 performance had improved and 97 per cent were seen within 26 weeks and 83 per cent seen within 13 weeks.

4.70 Variations against the standard continue to be marked from specialty to specialty (see **Figure 21**). In major specialties figures for the quarter ended 30 September 1995 show patients requiring appointments for General Surgery wait least with 91 per cent seen within 13 weeks and 99 per cent within 26 weeks. For Trauma and Orthopaedics the figures were 73 per cent seen within 13 weeks and 94 per cent within 26 weeks. Clinics not meeting the standards are required to have action plans in place to reduce the maximum waiting times.

Hospital and Community Health Services - financial performance

Financial performance of health authorities

4.71 Health authorities were responsible for spending over £20 billion on patient care during 1994-95. In doing so they were expected to:

- manage their resources to live within the cash limited allocation made available to them
- achieve an aggregate increase in efficiency of at least 2¼ per cent.
- Overall the authorities managed to utilise their cash resources fully without overspending. In addition the reported performance of the health authorities suggests that the overall target efficiency gain was achieved.

Financial performance of trusts

4.72 In 1994-95, the latest year for which trusts have published accounts, 309 of the 419 operational Trusts achieved all of their financial duties. Of the 110 who did not meet one or more of their financial duties 50 did so for technical accounting reasons. Material failures within the remainder are the subject of plans, to ensure improvements in future performance.

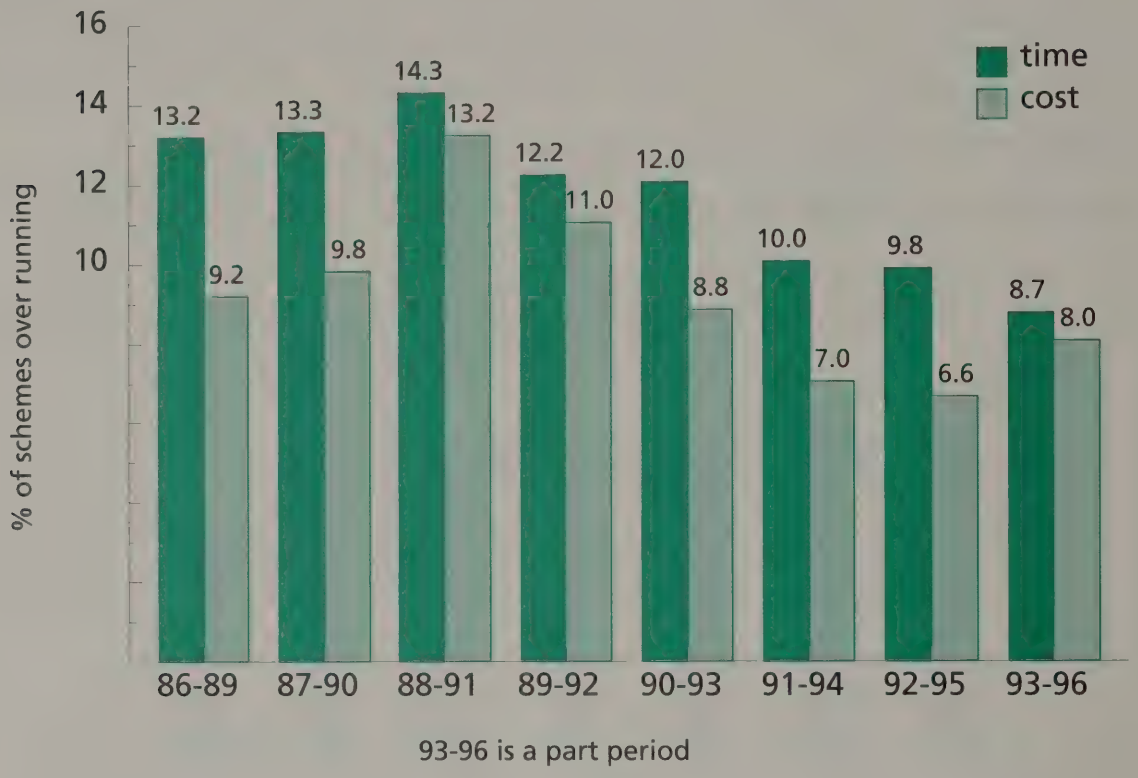
4.73 The NHS Executive has issued guidance to the NHS on Public Sector Payment Policy. The guidance stated that compliance with Government Accounting Regulations will appear as a note to the account in both NHS Trusts Annual Accounts and Annual Reports from 1994-95 onwards. Government Accounting says that all external suppliers must be paid within 30 days of receipt of goods, or a valid invoice, whichever is the later, unless covered by other agreed payment terms.

4.74 An Analysis of the 1994-95 Accounts shows that NHS Trusts paid 53 per cent of their bills within the target set by the Government Accounting Regulations. From the 1st April 1995 NHS Executive Regional Offices have monitored individual NHS Trust performance in this area. Data from 1995-96 Quarter 2 returns shows that NHS Trusts were now paying 67 per cent of their bills within target. A further improvement is expected at Quarter 3. Where individual Trusts are not complying with the prompt payment code NHS Executive Regional Offices are requiring them to submit a timetable showing when they will achieve compliance.

Capital Building Programme

4.75 At end September 1995, time and cost overruns had stabilised at 8 per cent for cost and 9 per cent for time against 13 and 14 per cent respectively in 1988-91 (see **Figure 22**).

Figure 22 - Time and cost performance - 3 year moving averages: 1986-89 to 1993-1996



Value for Money

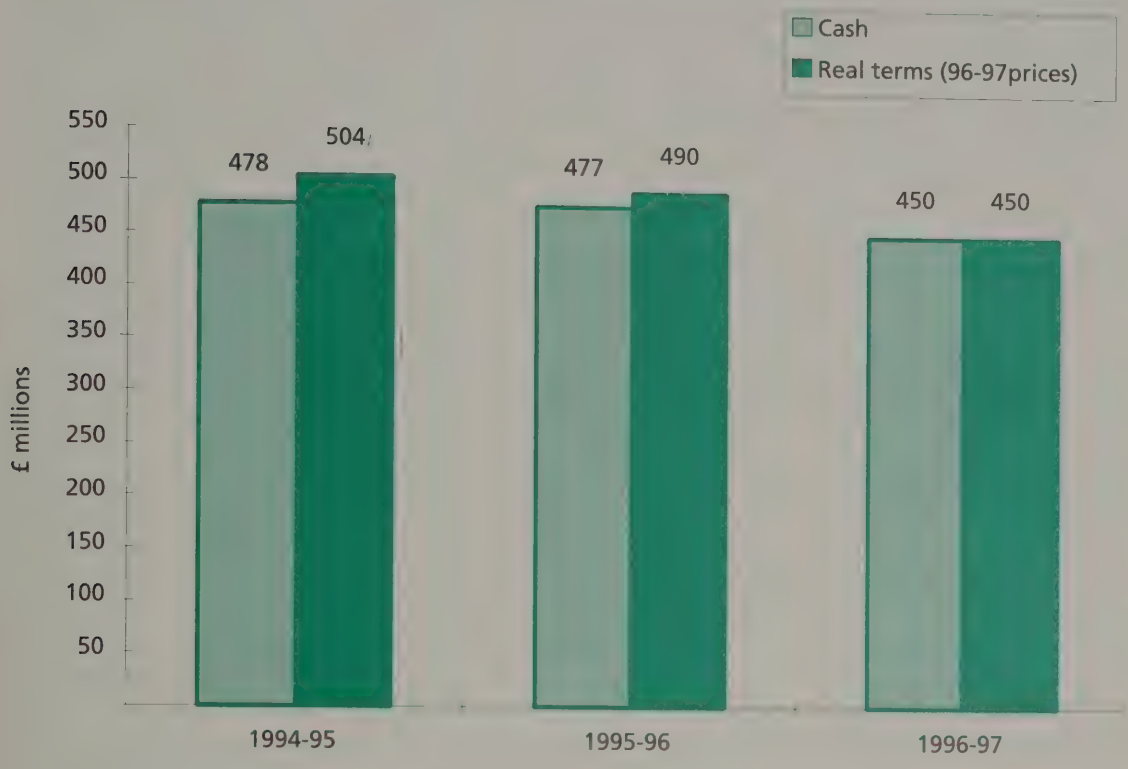
Health authority costs and trust management costs

4.76 In October 1995 the Secretary of State announced an overall requirement to achieve a 5 per cent cash reduction in the costs of running health authorities and in trust management costs in 1996-97 compared with planned spending in 1995-96. The management function in the NHS has been built up since the Griffiths Report in 1983 which portrayed the NHS as an undermanaged organisation but it is important that the management function is subject to proper scrutiny to ensure that it is delivered efficiently in the same way as every other aspect of the health service. The savings from reducing costs will be available for patient care.

4.77 **Figure 23** below shows that the cost of running the new health authorities in 1996-97 is planned to be some £450 million, 5.5 per cent below planned spending by Health Authorities and FHSAs in 1995-96. In real terms costs will have fallen by nearly 11 per cent compared with 1994-95 spending.

4.78 Information on spending on Trust management costs in 1995-96 based on the Audit Commission's M2 definition of management costs is not yet available. ("M2" consists of the salaries of all those managers, excluding those who are primarily clinicians, earning over £20,000 per annum, those in a few specified posts regardless of salary, the salaries of all other staff working in corporate functions, and the cost of management consultancy.)

Figure 23 - Health authority costs: 1994-95 to 1996-97



Efficiency Scrutiny

4.79 An efficiency scrutiny into the burdens of paperwork in NHS trusts and health authorities, led initially by Jim Hammond, Chief Executive of East Gloucestershire NHS Trust and then by Christina Edwards, Director of Business Development, Essex Rivers NHS Trust, began work in November 1995. Its remit was:

- to identify achievable reductions in the administrative burden associated with the work of NHS trusts and health authorities, particularly to look at ways of simplifying the processes and transaction costs associated with contracting;
- to consider the scope for reducing the number of central returns required by the Department of trusts and HAs; and
- to review and make recommendations on the frequency and volume of information issued to trusts and HAs by the Department

4.80 The Scrutiny Team will report to the Secretary of State before the end of March 1996 with recommendations for implementation within two years.

Other Value for Money Initiatives

4.81 Action is underway on many other fronts to improve value for money in the NHS. Current examples are given below.

4.82 **NHS Supplies** The NHS Supplies Authority were set performance targets in 15 key areas for 1994-95 and in 11 cases they fully met or exceeded the targets. In particular on contracts with an overall value of £1.6 billion which were negotiated by NHS Supplies in 1994-95 the savings achieved amounted to £80.4million, or 5 per cent. Operating costs were again reduced by £1million over the year, despite a 6 per cent increase in stock sales by value. Management of logistics operations was streamlined by replacing divisional managers with a national management team, based in Burton. Plans were set in train for a similar recasting of purchasing services into national management by customer group. The number of sites taking up their highly-regarded materials management service at ward or department level increased from 4,000 to 5,700, and there was continuing rationalisation of warehouse sites, monthly stock levels and stock turnover rates. Though NHS trusts are free to make their own provision for supplies services on a value for money basis some 98 per cent continue as customers of NHS Supplies, and total trust business continues at a sustained high level. The arrangements for national pricing with a price guarantee had extended to 75 per cent of catalogue sales by volume by October 1995. The average time taken to pay suppliers reduced to 38 days by April 1995, and continues to improve.

4.83 **Clinical negligence** Employers in the National Health Service are responsible for the negligent acts and omissions of their employees, including hospital doctors and dentists (but not General Practitioners or other self-employed practitioners). The costs to the NHS of clinical negligence claims have been rising steadily in recent years: although exact figures are not available, the estimated costs in England are shown in **Table 17**.

Table 17 - Clinical negligence costs: 1990-91 to 1994-95

Year	Estimated amount (£ million)
1990-91	60
1991-92	80
1992-93	100
1993-94	125
1994-95	155

4.84 Clearly, risk management must first focus on avoiding negligent acts and omissions. But in support, the Department has established a Clinical Negligence Scheme for Trusts (CNST) to help trusts spread the impact of any liability in this area. The CNST, which, subject to Parliamentary approval, will be operational from 1 April 1995, is a"pooling" arrangement which allows member trusts to pay a fixed annual sum into the scheme. This sum can attract discounts where the trust can demonstrate good risk and claims management strategies. In return, the scheme will make a contribution towards the costs of clinical negligence claims arising during the membership of the trust. So far, more than 80 per cent of trusts have applied to join the CNST.

4.85 **Absenteeism** High staff absence rates are a drain on the resources of any organisation. Several NHS trusts have had significant success in controlling absenteeism. For example:

- the Royal Shrewsbury Hospital reduced its absence rate from 6 per cent in 1993 to below 3 per cent by June 1994, saving in excess of £1 million;
- Oldham NHS Trust reduced sickness absence by almost 5 per cent between 1990-91 and 1993-94, saving £120,000 in sick pay in 1993-94 alone; and
- the Royal Liverpool University Hospital reduced sickness absence by 2 per cent, saving £1 million over two years.

4.86 These improvements in absence rates were achieved through a people and process focused approach; combining improved communications, education and support mechanisms with absence level targets, regular monitoring, pre-employment screening and return to work interviews.

4.87 Examples of good practice in this area, and on other value for money topics, is widely circulated throughout the NHS.

Costing for contracting

4.88 Costing for Contracting guidance has been gradually developed since April 1991. It is designed to improve the quality of costing information available within the NHS and thus to aid the development of the internal market. It provides a standardised approach or methodology to costing. Additionally, and in conjunction with the developments in costing, national standard groupings which describe and define the healthcare provided. have been devised. These groups, known as healthcare resource groups (HRGs), consist of treatment episodes which are clinically similar and consume similar resources. Costed HRGs are designed to inform the contracting process by allowing health authorities to make comparisons between trusts and year on year comparisons for a particular trust.

4.89 In 1994-95 providers were required at a minimum to cost their activity down to specialty level and calculate an average specialty cost. The 1995-96 guidance extended the minimum requirement to building up the costs of healthcare delivered using HRGs within a single acute specialty chosen from Ophthalmology, Gynaecology and Orthopaedics. This is being further developed for 1996-97 to include 6 specialties, Ophthalmology,Gynaecology, Orthopaedics, Urology, General Surgery and E.N.T. The published extra-contractual referral (ECR) tariff for the 6 specialties named above must be based on costed HRGs.

Corporate governance

4.90 Codes of Conduct and Accountability were issued to all NHS boards in April 1994. These Codes ensure that the public service values of openness, probity and accountability lie at the heart of the way business is conducted at board level. An evaluation project is now underway to determine the impact the codes have made on the way NHS boards manage their organisations. In particular, it will look at reporting at board level, support for the board, delegation by the board and board development. The project will be completed early in 1996-97.

4.91 In response to a need identified by the Corporate Governance Task Force, a Corporate Governance Framework Manual is in preparation. This aims:

- to bring together all extant guidance on financial issues;
- to eliminate any duplications or conflicts in existing guidance;
- to ascertain whether the guidance is complete and, if it is not, fill in the gaps;
- to arrive at a better way of promulgating regulations, advice and guidance to the service on an ongoing basis.

The first material for the manual was issued in October 1995.

Family Health Services

4.92 Summary performance data are shown in **Tables 18** to **21**. The largest elements of the FHS are the cost of prescribed drugs, and the pay and expenses of family doctors and dentists who provide care as independent contractors. A large part of family doctors' and dentists' expenses is made up of the pay of practice support staff such as nurses and receptionists; for example, GPs have been encouraged to take on additional staff to improve the effectiveness and range of care provided by practice teams. In addition, many conditions can now be treated in the community rather than in hospital, either by primary care teams led by the patients GP or by new drug therapies. Although the remuneration systems are designed to encourage efficiency, generally by seeking to encourage contractors to keep their expenses below average, costs per contractor have risen in real terms over the longer term, as more health care is delivered in the primary setting by more staff. Future developments in primary care are discussed in paragraphs 4.138 to 4.155.

General medical services

4.93 GPs are increasingly important in ensuring that the NHS develops in the way that best meets the needs of patients: of all the professionals and managers in the NHS, family doctors have the most comprehensive contact with their patients, both in surgery and in patients' own homes. The expansion of the GP fundholding scheme and proposals for a stronger partnership between health authorities and all GPs (fundholders and non-fundholders) are outlined at paragraph 4.149. Paragraph 4.37 describes how GMS funds were spent in 1994-95 in maintaining high standards. Specific initiatives to improve and strengthen services during 1995 are outlined below.

4.94 **Services outside normal hours**. The Department and the General Medical Services Committee have reached an agreement on new arrangements for services outside normal surgery hours:

- A £38 million **Out of Hours Development Fund** has been allocated to Family Health Services Authorities in 1995-96 to support improvements to out of hours services. Amendments have been made to the Statement of Fees and Allowances to increase the range of help which FHSAs can give to practices for their out of hours services.

- A **Patient Education Campaign** will begin in 1996 to encourage patients to make the most appropriate use of out of hours services.

- Changes to Regulations will shortly be made to allow a GP to **transfer out of hours responsibility** in whole or in part to another GP.

- A **single night consultation fee** will shortly replace the previous two-tier fee

- The data reporting requirements of the **Health Promotion Programme** have been reduced.

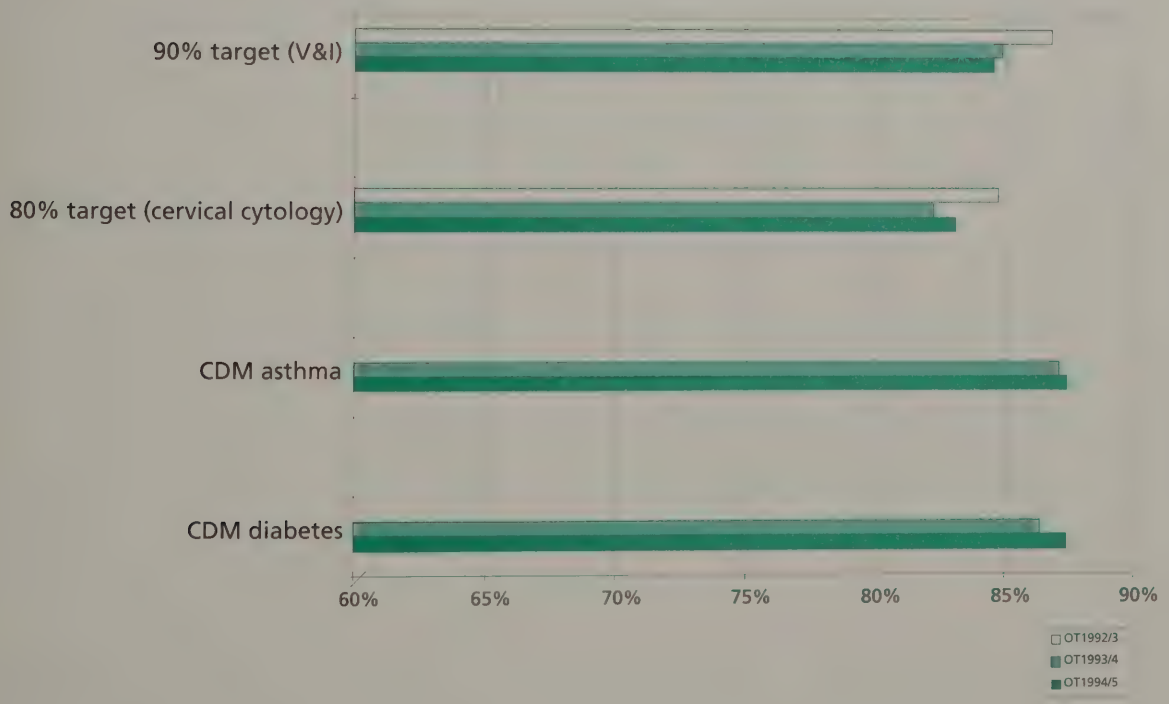
4.95 **Violence against GPs** In line with the recommendations of a joint Working Group with the profession, established in response to GPs' concerns about their personal safety, GPs' Terms of Service have been changed to allow for the immediate removal of a patient from a GP's list where the patient has assaulted the GP, or has behaved in such a way that the GP has fears for his or her safety, and has made a complaint to the police.

4.96 **GP/FHSA links** Electronic links between GPs and FHSAs are being developed under the GP/FHSA Links project which aims to replace a paper based system with electronic data interchange. The Project has set out to achieve this with two modules, the Registration module, for GPs to use for notifying FHSAs of new patient registrations, and the Items of Service Module, which is to help with the handling of GP claims for payment for particular services. By November 1994, electronic links with practices had been achieved for the purposes of registration with 89 FHSAs. The Items of Service module is the next step for practices successfully linked to their FHSA using the registration module. The main benefits are: speedier claims processing; faster transfer of patient medical records (in days not weeks, in line with Patients Charter standards); reduced clerical effort at practices and FHSAs; the elimination of the risk of losing paperwork in transit; and audit trails more easily established.

4.97 **GP numbers** The steady growth in GP numbers is illustrated in table 18. As a result of this growth, average list sizes are now 1,900 - more than 9 per cent lower than in 1984-85. In 1984-85 women accounted for just 18.4 per cent of all GPs. By 1990-91 this had risen to 23.8 per cent and by 1994-95 to 27.7 per cent. The increasing proportion of women in the workforce has been reflected in an emerging trend away from full-time working. Since 1990, when the present flexible working arrangements were introduced as part of the new GP contract, the proportion of GPs working part-time has risen from 5.5 per cent to 11.2 per cent. The result of the growing number of GPs, combined with the changing structure, is a more flexible workforce offering patients more choice. For example, most women can now register with a woman GP if they wish to.

4.98 **Target payments** GPs make a substantial contribution to the health of the population by achieving high targets for vaccination against childhood illnesses and for cervical cytology to detect cervical cancer. At April 1994 over 91 per cent of GPs were reaching the higher 90 per cent target for childhood immunisation, and 96 per cent reaching the 70 per cent target. On cervical cytology 89 per cent were reaching the higher 80 per cent target and 99 per cent the 50 per cent target. There are, however, fairly substantial variations in performance across the country. The Department is encouraging health authorities to support GPs in improving coverage in poorer performing areas.

Figure 24 - Family Health Services practice coverage across various indicators - England



4.99 **Health promotion** Over 90 per cent of GPs continue to participate in health promotion programmes to reduce risk factors for coronary heart disease and stroke. In line with the recommendations of the GP Bureaucracy Efficiency Scrutiny 'Patients not Paper' the data reporting requirements of the health promotion scheme have been substantially reduced from 112 data fields to only 8. Avoiding unnecessary bureaucracy in this way will help GPs and practice staff concentrate on health promotion interventions. Almost 90 per cent of GPs are participating in organised programmes of care for patients with asthma and diabetes.

4.100 **'Patients not Paper' - GP Bureaucracy Efficiency Scrutiny** In July the GP Bureaucracy Efficiency Scrutiny published its recommendations for substantial reductions in paperwork associated with general practice in its report 'Patients not Paper'. Ministers and the Chief Executive are fully committed to implementing the recommendations, which will result in a reduction of an average 575 forms per GP per year, or 1,700 per average practice. This saving represents two thirds of the current total of forms completed by GPs. The main themes of the recommendations are:

- Fewer, better forms and more streamlined ways of working;
- Making best use of information technology; and
- Supporting practices to cope more effectively with necessary paperwork.

Most of the recommendations are expected to be fully implemented by December 1996.

4.101 **General efficiency and value for money** For general medical services, the main measure of activity currently available is the number of contacts between patients and members of the primary health care team. However, data on the number of patient contacts are not sufficient, on their own, to form the basis of an activity index. Information on the quality or effectiveness of the services provided is also needed if an activity index is properly to address value for money. A working group has been set up to advise on what represents efficient and effective performance in the GMS, covering a range of GMS work including the effective use by GPs of hospital services, and how this can be assessed in terms of national accountability and national performance management without adding to bureaucracy. The group has considered the extent to which measures of GMS efficiency and effectiveness can be made operational within the period 1997-98 to 1998-99. The recommendations of the group will be subject to consultation.

Table 18 - Key statistics on general medical services 1984-85 to 1994-95

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	1984-85 to 1993-94	1994-95 to 94-95
Number of General Medical Practitioners	23,640	25,622	25,686	25,968	26,289	26,567	12.38%	1.06%
Expenditure								
Total General Medical Services (£000s)	977	1,948	2,303	2,453	2,556	2,691	175.44%	5.28%
Gross current expenditure on General Medical Services per General Medical Practitioner (£ cash)	41,346	76,045	89,655	94,452	97,233	101,291	144.98%	4.17%
Real terms 1994-95 prices (£)	67,634	88,159	97,832	99,033	99,061	101,29	144.76%	2.25
Cash limited expenditure per GMP included in gross expenditure above (£)	n/a	18,114	24,933	26,057	27,202	29,641	n/a	8.97%
Real terms 1994-95 prices (£)	n/a	21,000	27,207	27,321	27,713	29,641	n/a	6.96%
Consultations								
Total number of consultations (millions) in Great Britain	227.0	288.40	255.20	273.10	301.90	268.40	18.24%	-11.10%
Total number of consultations per GMP in Great Britain	8,020	9,420	8,310	8,790	9,600	8,450	5.36%	-11.98%
Real terms cost per consultation (1994-95 prices) in Great Britain	8.43	11.59	15.05	14.37	13.21	15.49	83.74%	17.34%
List sizes								
Average list size at 1 October each year	2089	1,942	1,947	1,922	1,902	1,900	9.05%	0.11%
Gross current expenditure on General Medical Services per patient on list after adjustment for estimated list inflation (£cash)	18.79	37.70	44.35	47.59	49.57	51.70	175.05%	4.28%
Cash limited expenditure per patient on list included in gross expenditure per patient (£cash)	n/a	9.33	12.80	13.74	14.30	15.60	n/a	9.08%
Staffing								
Number of GP practice staff (WTE)	25,994	45,575	48,730	51,020	53,952	51,833	99.40%	-3.93%
Number of WTE practice nurses (included in GP practice staff)	1,924	7,698	8,776	9,121	9,605	9,099	372.92%	-5.27%

Notes:

a) Cash limited expenditure commenced 1990-91;

b) General Medical Services are the personal medical services provided by General Medical Practitioners;

c) All cash information taken from Appropriation Accounts;

d) Practice staff numbers are whole time equivalents;

e) The reduction in practice staff from 1993-94 may be due to the under reporting of numbers by GP fundholders;

f) Consultations data are taken from the General Household Survey covering Great Britain rather than England only.

Pharmaceutical services

4.102 These services, mainly provided by community pharmacies, consist of the supply to patients of drugs, medicines and listed appliances which are prescribed by general practitioners. Over 80 per cent of the gross cost of the services is accounted for by the "drugs bill" with fees to contractors for dispensing prescriptions and to doctors for personally administering some drugs (such as flu jabs) making up the remainder. Offset against these costs is the income from prescription charges collected from patients.

4.103 **Drugs Bill** The "drugs bill" is the cash amount paid to contractors in respect of drugs, medicines and listed appliances which have been prescribed by GPs. In 1995-96, the "drugs bill" is expected to increase in real terms by less than 6 per cent. This compares with an increase of 7.4 per cent in real terms in 1994-95 - but is still higher than the average real terms increase over the last 10 years (5.2 per cent). The number of prescriptions increased by 2.7 per cent in 1994-95, almost half the rate of increase of the previous year. A slightly higher rate of growth, between 3 and 4 per cent, is expected for 1995-96. The gross cost of each prescription dispensed (including dispensing fee) rose by 2.7 per cent in real terms in 1994-95. While the rate of growth in the drugs bill is forecast to be lower in 1995-96 than in each of the last three years , further action to restrain growth in the drugs bill to more sustainable and affordable levels will continue. This will include addressing inappropriate and uneconomic prescribing, consistent with the policy that all patients should receive the medicines they need. **Figures 25** and **26** show the growth in the drugs bill over the last decade in both cash and real terms.

Figure 25 - FHS Drugs Bill cash 1984-85 to 1994-95

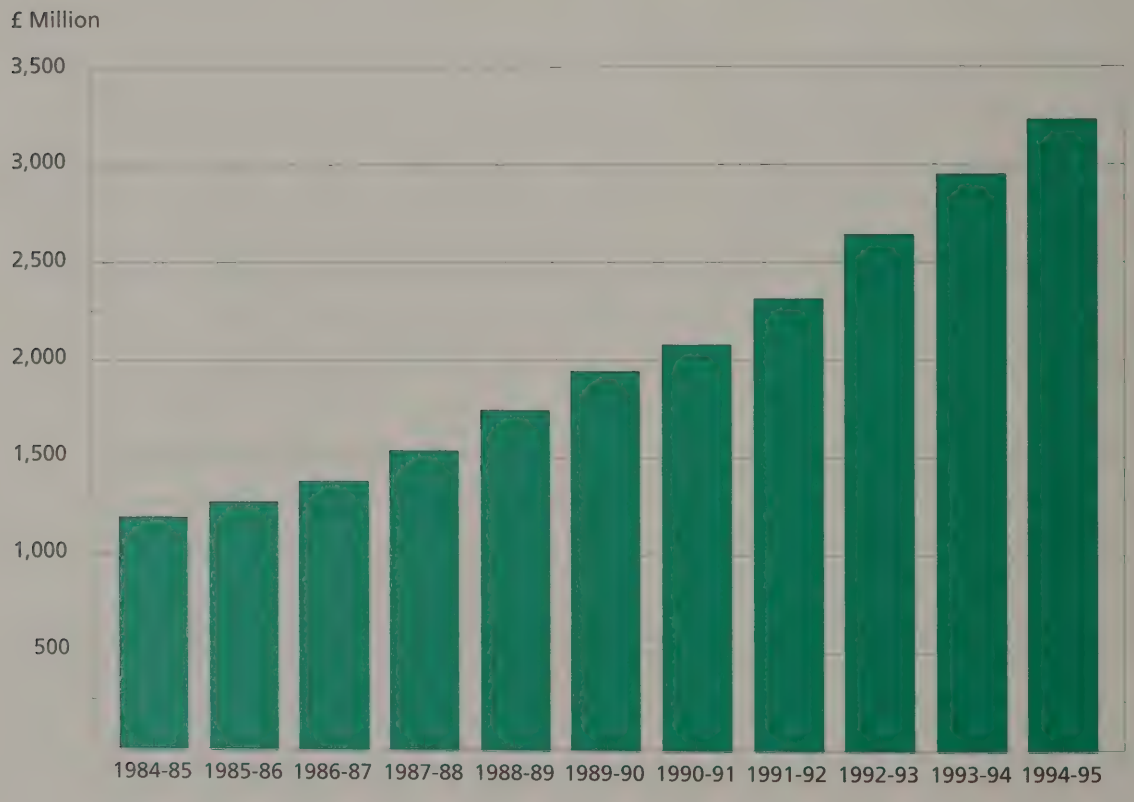
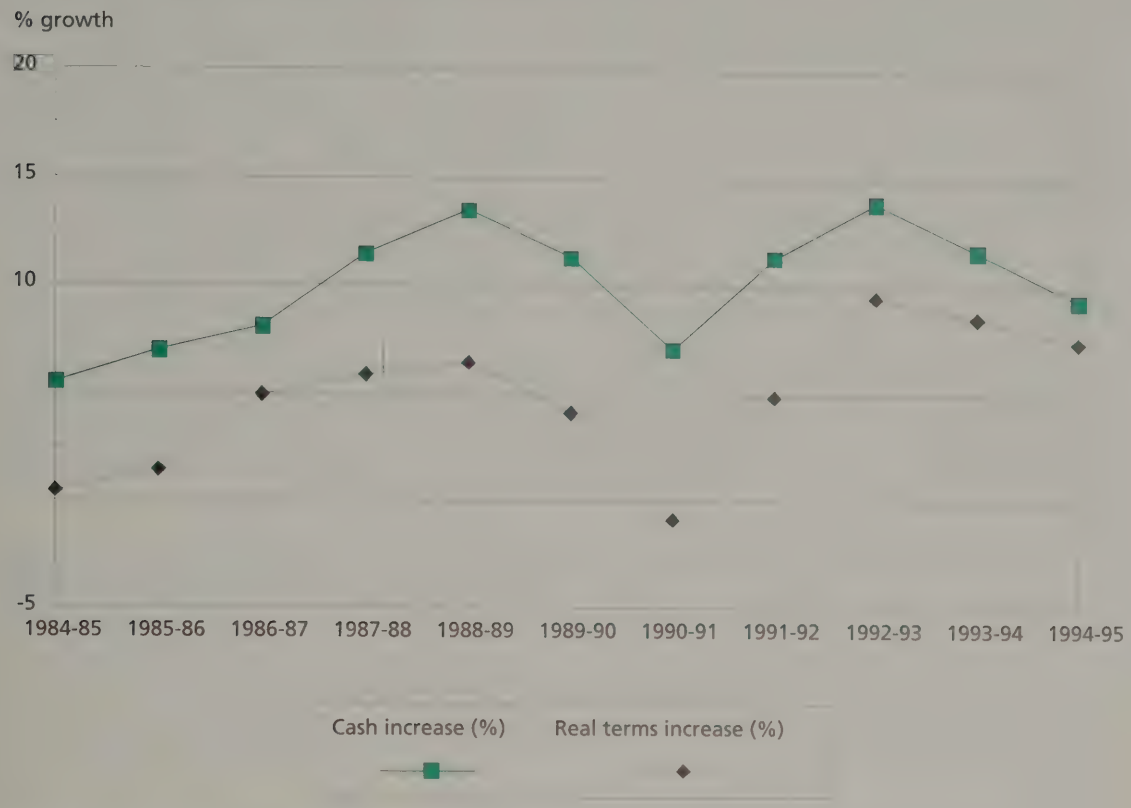


Figure 26 - FHS Drugs Bill: Cash and Real Terms Increases 1984-85 to 1994-95



Cost Effective Prescribing

4.104 Efforts to promote and support rational GP prescribing have continued through a comprehensive programme of work. Measures taken include:

- Changes in the prescribing allocations methodology for 1996-97, linked to a programme of action aimed at tackling the underlying reasons why some GPs spend more on drugs;
- GP fundholders have continued to lead the way in demonstrating that growth in prescribing costs can be contained without detriment to patient care. By 1 April 1996, fundholders are expected to cover around 53 per cent of the population. In the first 4 years of the scheme, the growth rate in their prescribing costs has been between 3-4 per cent lower than that of other GPs;
- The number of non-fundholding GP practices participating successfully in practice-based prescribing incentive schemes trebled from around 500 to 1500 in 1995-96. The successful practices helped to save about £30 million on their prescribing costs, thereby qualifying to receive about £7 million to spend on improving patient services;
- The Prescribing Analysis and Cost System (PACT), which helps FHSAs and GPs to monitor prescribing behaviour, was significantly improved during 1995. An enhancement of the computerised version was installed in all FHSAs, allowing for a much more detailed examination of prescribing patterns of GP practices;

- Continued promotion of generic products where clinically appropriate. The rate of generic prescribing has increased from 44 per cent in 1992-93 to 48 per cent in 1993-94 and continues to rise in 1995-96;

- Active encouragement to practices to review and audit their repeat prescribing which accounts for some 70 per cent of all GP prescribing by cost;

- All FHSAs have medical advisers, and nearly all have pharmaceutical advisers, who regularly visit practices to offer professional advice on prescribing issues; and

- Greater use of practice formularies which are best developed at a local level.

It is widely recognised that the choice and usage of medicines in hospitals has an important influence on GP prescribing. Guidance has therefore been issued on the role of purchasers (both health authorities and GP fundholders) in developing an integrated approach to prescribing and the managed entry of new drugs into the NHS. Guidance on the introduction of beta-interferon (a new drug for multiple sclerosis) was issued in November.

4.105 **Nurse Prescribing** Under legislation introduced in October 1994, appropriately qualified nurses in eight GP fundholding demonstration sites are able to prescribe from a limited list of medicines and wound management products. The aim of this initiative is to ensure patients receive more convenient and better targeted care in the community and have their necessary medicines and dressings prescribed through health professionals whom they see on a day to day basis. From April 1996 it is proposed to extend the scheme to a locality covered by a single Community Trust. Continuous evaluation is being carried out to assess the effectiveness of the measures as the scheme develops.

4.106 The **Pharmaceutical Price Regulation Scheme** (PPRS): is a voluntary scheme between Government and the Pharmaceutical industry, its objectives are to:

- secure the provision of safe and effective medicines to the NHS at reasonable prices, helping to ensure that the NHS pays no more than necessary for prescribed medicines;

- promote a strong and profitable pharmaceutical industry in the United Kingdom capable of such sustained research and development expenditure as should lead to the future availability of new and improved medicines; and

- encourage in the United Kingdom the efficient and competitive development and supply of medicines to pharmaceutical markets in this and other countries.

4.107 **Value for Money** On the supply side, measures to help ensure better value for money include the following:

- The **Selected List Scheme** was extended to cover seventeen therapeutic categories at the end of 1992. Under this Scheme drugs within the categories may not be prescribed on the NHS where Ministers decide, on the advice of the independent Advisory Committee on NHS Drugs, that there are effective alternatives available at lower cost; and

- The **appropriate purchasing of drugs** Some of the recent growth in the primary care drugs bill is attributable to an inappropriate increase in the amount of "high tech" health care for patients at home being prescribed by GPs. The need for continuous ambulatory peritoneal dialysis (CAPD) or certain intravenous treatments are examples. In some cases this is not cost effective and blurs the link between clinical and financial responsibility for the care of patients. Responsibility for appropriate areas of this expenditure has therefore been transferred into the main hospital and community health services budget to allow the development of local or central purchasing arrangements to ensure better value for money.

4.108 **Table 19** gives information on the level of activity and on the gross cost of the pharmaceutical services per prescription broken down to show the drug and dispensing costs separately. It shows that the average cost of dispensing prescriptions has fallen by 4 per cent in real terms since 1993-94 continuing the downward trend of recent years. (See **Figure 27**). The dispensing cost per prescription has fallen from its high point in 1986-87 of £1.78 to £1.45 (1994-95 prices), a real terms reduction of over 18 per cent. Some 90 per cent of all prescriptions are dispensed by community pharmacies. Pharmacies are also steadily increasing the range of services available to patients. Recent changes to the pharmacists' fee structure will further encourage the better use of pharmacists' professional skills, including a new professional allowance to recognise their key role in advising patients about all aspects of their medication and to encourage even higher professional standards. The Department has also extended the Essential Small Pharmacies Scheme so that small pharmacies which are more than one kilometre from the next nearest pharmacy can claim a special payment to assist them to stay open, therefore helping to maintain easy public access to pharmacies. 1995 also saw the introduction of local pharmacy budgets under which FHSAs are able to agree their own fees for certain pharmaceutical services. The intention is progressively to increase the scope of local budgets so that health authorities can match these services more closely to the needs of the local population.

Figure 27 - Cost of Dispensing Prescriptions by Pharmacists and Appliances Contractors 1984-85 to 1994-95

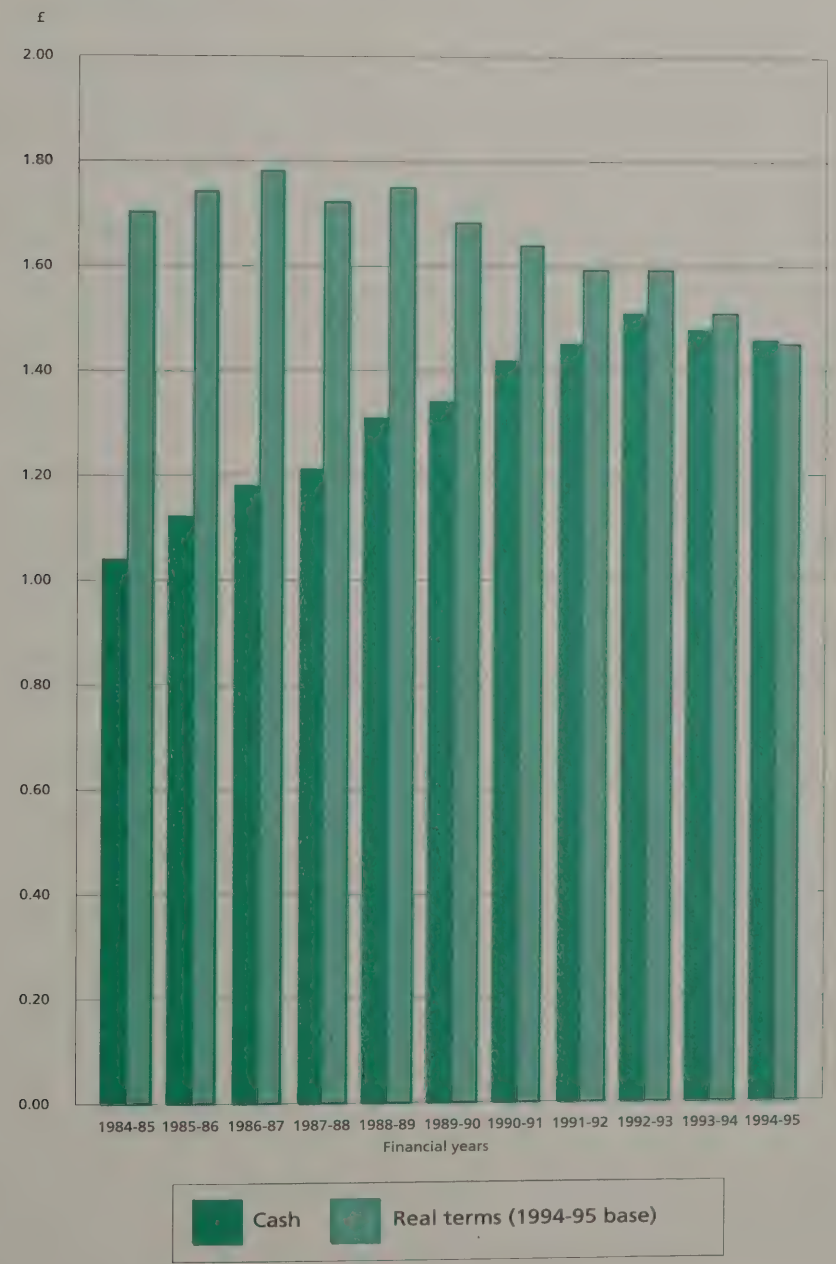


Table 19 -Family health services: key statistics on pharmaceutical services

		1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95	% change 1993-94 to 1994-95
Pharmaceutical Services [1]									
Prescriptions (thousand) [2]		345,110	396,580	415,370	432,370	455,320	467,790	35.5	2.7
Number of contracting pharmacies [3] [4]		9,210	9,760	9,760	9,760	9,770	9,770	6.1	0.1
Average number of prescriptions dispensed by pharmacy and appliance contractors		33,430	35,740	37,780	39,250	41,290	42,380	26.8	2.6
Cost of pharmaceutical services per prescription (1994-95 prices) (£) [2] [5]	Gross	7.36	7.75	7.72	8.02	8.18	8.40	14.1	2.7
	Drug	5.66	6.11	6.13	6.43	6.67	6.95	22.8	4.2
	Dispensing	1.70	1.64	1.59	1.59	1.51	1.45	-14.7	-4.0
Cost of drugs and appliances in real terms (1994-95 prices) (£m) [2] [6]		1,949	2,411	2,529	2,769	3,006	3,230	65.7	7.4
Percentage of prescriptions chargeable [7]		27.2	21.6	20.0	19.0	17.9	17.3	-36.4	-3.3

(1) Pharmaceutical services are mainly the supply of proper and sufficient drugs, medicines and listed appliances which are prescribed by general practitioners.

(2) Numbers relate to prescription items except for 1984-85 which is based on fees; figures include prescriptions dispensed by chemists, appliance contractors, dispensing doctors and personal administration.

(3) Excludes appliance contractors and dispensing doctors.

(4) From 1991-92 figures are shown as at 31 March (eg. 1991-92 is number as at 31 March 1992). Figures for earlier years refer to 31 December.

(5) Gross pharmaceutical expenditure is total payments (drug costs and dispensing fees) to contractors less recoveries from health authorities and the Ministry of Defence (in respect of hospital and armed forces prescriptions dispensed in the community) and excluding refunds of charges.

(6) Includes receipts under the Pharmaceutical Price Regulation Scheme.

(7) Chargeable prescriptions based on a calendar year and include items dispensed to holders of prescription prepayment certificates. Percentages are calculated on prescriptions dispensed by community pharmacists and appliance contractors.

4.109 **Community Pharmacy** The Department remains fully committed to developing the professional role of community pharmacists where it can be shown that it is cost-effective to do so. The Department has funded a number of initiatives aimed at raising standards within pharmacies and making fuller use of pharmacists' skills. These include the development of a comprehensive programme of continuing education and training and a number of pharmacy audit initiatives to facilitate community pharmacists' participation in clinical audit.

4.110 Since 1992-93 nearly £10 million has been made available to encourage participation by pharmacists in local needle exchange schemes and in the safe disposal of unwanted medicines. The Department has made about £1 million available during 1995-96 for local projects to examine the contribution community pharmacists can make to improving the quality and cost effectiveness of GP prescribing. The 17 projects range from repeat prescription review of elderly patients to pharmacist-led prescribing seminars.

4.111 At the local level, a large number of FHSAs and social service departments have involved pharmacists in a wide range of service developments. These include participation in health promotion campaigns and domiciliary visits. The Department intends to build on FHSAs' initiatives through the development of locally contracted pharmacy services. This will allow local management of the two services to be devolved, giving FHSAs and local pharmacists scope to tailor services around the needs of their various populations.

General Dental Services

4.112 General Dental Service Reforms On 5 April 1995 the Government announced its plans to improve NHS dentistry in two phases with immediate action to deliver improvements to the current system and continued work on the long term reforms of the structure of NHS dentistry. The reform of the current system has four major elements in the package:

- reform of child dentistry. This is the highest priority. Payments to dentists for caring for children will be made more sensitive to treatment need, in order to focus care more closely on those with higher levels of disease. The Government is committed to consolidating and developing recent improvements in child oral health;

- continuing care payments to dentists for registered adult patients. These will be restructured to deliver improved value for money;

- more rigorous prior approval procedures for monitoring treatment will be introduced, to make sure that the treatment provided is clinically essential and that there is no clinically acceptable, less costly, alternative. This will ensure the most effective use of resources; and

- to meet the needs of patients in areas of the country where there is difficulty in obtaining NHS treatments under the General Dental Service, the safety net role of the Community Dental Service will be strengthened.

4.113 These proposals have been welcomed by the dental profession. The Government is now working closely with the profession to develop these measures for implementation.

4.114 For the long term, the Government has confirmed its intention to develop a system of local contracts between health authorities and dental practices. A locally sensitive system was supported by both Sir Kenneth Bloomfield's Fundamental Review and the report of the Health Select Committee. Pilot schemes require primary legislation and the Government will seek the earliest opportunity to introduce this.

4.115 Overall the number of courses of treatment for adults and the average number per dentist have grown over the last ten years by 19 and 6 per cent respectively, although these measures are subject to significant variations from one year to the next. The average numbers of children registered with a dentist grew between 1991-1992 by about a quarter, although this was still within the "start-up" phase because formal registration was only introduced in October 1990 and registration can last up to two years. The average increased by a further 1.7 per cent in 1993 but fell by 1 per cent in 1994. This apparent small reduction may be due to action at the Dental Practice Board to improve screening to eliminate duplicate registrations. Although the average cost of an adult course of treatment increased by 1.8 per cent in real terms in 1994-95 compared with 1993-94, the cost when compared to 1984-85 was down by nearly 5 per cent.

Table 20 - Key statistics on general dental services

General Dental Services	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95	% change 1993-94 to 1994-95
Adult courses of treatment (thousands)	20,870	22,560	24,270	25,140	24,850	24,910	19.4	0.3
Adult courses of treatment per GDP	1,480	1,460	1,570	1,630	1,580	1,570	5.7	-0.4
Children registered into capitation (thousands) [1]	-	-	5,800	7,100	7,400	7,370	-	-0.4
Children registered per GDP [2]	-		375	461	469	464	-	-1.1
Average gross cost of adult courses of treatment in real terms (1994-95 prices) (£) [3]	39.38	41.97	43.43	41.00	36.86	37.51	-4.7	1.8

(1) Number of children registered as at 30 September. Capitation registrations only began with the introduction of the new dental contract from 1 October 1990.

(2) Average number of children registered per dentist at 30 September, including principals, assistants, and vocational trainees although patient registrations are formally attributed to principals only.

(3) Average gross cost of adult courses of treatment, as measured by Dental Practice Board data recording only item of service fees payable for such treatments up to 1990-91. From 1990-91 onwards, costs are based on item of service fees payable and adult continuing care payments. Prior to 1986-87, data is only available on a calendar year basis.

Budget 1995 deflators used

General Ophthalmic Services

4.116 General ophthalmic services underwent substantial change on 1 April 1989 when NHS sight tests were restricted to certain priority groups, that is, children, students aged under 19 in full time education, adults on low incomes and those with certain special needs. Meaningful comparisons are therefore only possible between 1990-91 and 1994-95, over which period there were rises of 54 per cent in both the number of sight tests paid for and vouchers reimbursed, reflecting both a recent growth in the number of people eligible for NHS sight tests and higher take-up. Year on year growth in the number of sight tests and vouchers between 1993-94 and 1994-95 was 7.5 per cent and 7.3 per cent respectively. See **Table 21**.

Table 21 - Key statistics on general ophthalmic services

General Ophthalmic Services	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95	% change 1993-94 to 1994-95
Number of NHS sight tests (thousands) (1)	9,882	4,154	4,979	5,528	5,935	6,383	(3)	7.5
Number of vouchers (thousands) (2)	-	2,432	2,844	3,185	3,485	3,741	-	7.3

(1) NHS sight tests were restricted to certain priority groups from 1 April 1989. Figures show number of sight test payments made in the year.

(2) Vouchers were introduced to help certain priority groups with the provision of glasses from 1 July 1986. Figures show number of vouchers reimbursed to practioners in the year, including payments for complex appliances.

(3) Comparison between 1994-95 and 1984-85 is potentially misleading because of the changes in eligibility for sight tests and vouchers as described in footnotes (1) and (2) above.

Budget 1995 deflators

Future Plans

4.117 The key objectives that the Secretary of State has set the NHS Executive for 1996-97 and the years ahead are:

- Implement The Health of the Nation strategy in, and through the NHS
- Ensure the quality and responsiveness of NHS services
- Ensure effective partnership between the NHS and other providers and purchasers of care to meet the needs for continuing care of the elderly, disabled and vulnerable people in the community
- Develop a primary care-led NHS where decisions about health care involve patients and their carers and are taken as close to patients as possible
- Ensure people with mental health problems are provided with a comprehensive range of secure, residential, in-patient and community services in the most appropriate setting in accordance with their needs
- Improve the cost effectiveness of NHS services, through formulating decisions on the basis of information about clinical effectiveness
- Ensure effective management of people
- Secure sustained improvement in the effectiveness of communications with staff, the public and the media, and to enable all NHS organisations to share information in a controlled environment through implementation of the IM&T infrastructure

4.118 These themes were reflected in the Priorities and Planning Guidelines for 1996-97, issued to the NHS in June 1995. The paragraphs that follow report on recent progress and future plans under each heading.

● Implement The Health of the Nation strategy in, and through the NHS

Health of the Nation and the NHS

4.119 Overall progress on Health of the Nation is reported in Chapter 3: this Chapter focuses on the NHS contribution. The strategy has an increasing influence on health authorities' plans to purchase services to meet the health care needs of local people. Most Directors of Public Health now feature Health of the Nation prominently in their annual reports on the health of their local populations. The work of health authorities, hospital and community units, and primary care teams ensures that commitments made in corporate contracts are underpinned both by management action at the local level and by suitable local programmes.

4.120 The NHS Executive is developing a performance management framework with Regional Offices and Health Authorities for Health of the Nation, using a variety of performance management indicators and taking into account local circumstances.

Health Outcomes

4.121 Increasingly the NHS is taking account of "health outcomes" research, concentrating on the results of health care to develop strategies for preventing illness and measuring effectiveness. For many major public health problems, "population health outcomes frameworks" are being developed. These show the relationship between different interventions to reduce the impact of a disease and emphasise how early successful interventions can reduce the need for later (possibly more expensive) ones. Health outcome frameworks can inform decision making, help clarify the information needed by the NHS to monitor progress in combating diseases and determine where NHS resources should best be targeted.

The Public Health Function in the NHS

4.122 Legislative changes to Health Authorities' structures have prompted a review of the extent of professional input to Health Authority planning and decision making. The Health Authorities Act 1995 will lay a duty on the new Health Authorities to make arrangements for taking professional advice in discharging their functions.

4.123 The replacement of Regional Health Authorities by Regional Offices of the NHS Executive has led to the delegation of a number of public health functions eg. cancer registries, cancer screening services and drugs databases. Some functions will be taken forward by health authorities working together and some have been delegated to individual health authorities. Regional Offices will retain a coordinating role in emergency planning. The NHS Executive has signed a service level agreement with the Public Health Laboratory Service, tailored for each region, to provide specialist support for communicable disease control. This has major benefits for the NHS.

4.124 Regional Directors of Public Health and their staff remain a crucial element in the overall public health function within the NHS. They will brief public health professionals working locally in health authorities and NHS Trusts on important policy developments, give advice on implementation and provide a link between the field and DH policy makers. They will continue to provide professional leadership and direction for the public health function as a whole and co-ordination of effort on the many issues which overlap population boundaries.

Ensure the quality and responsiveness of NHS services

4.125 The NHS reforms have placed an important emphasis on "putting patients first". This means providing and developing health services that are responsive to the needs of users. This can best be achieved through a partnership of NHS service users and those who work in it.

Patient Partnership

4.126 Traditionally, however, it was assumed that the doctor or nurse knew what was best for the individual patient and that the wider health service knew best how health services should develop. These attitudes have been slowly changing. Accelerating the pace of that change and achieving active partnership with patients and the wider community is now a major challenge for the NHS.

4.127 The Department is seeking to develop user involvement in the NHS, in particular because:

- patients want more information about their health condition, treatment and care, and have a right to this under the Patient's Charter;
- there is evidence that involving patients in their own care increases patient satisfaction and improve health care outcomes;
- the assessment of clinical effectiveness and outcomes must include the patient's perspective of their health;
- services are more likely to be appropriate and effective if they are planned on the basis of users' needs; and
- the users of public services, as tax payers, should have more say in how they are developed, what services are provided and to what standards

4.128 **Patient Partnership** works at individual and community levels.

Individual level

- to promote user involvement in their own care, as active partners with professionals; and
- to enable them to become informed about their treatment and care and to make informed decisions and choices about it if they wish.

Community level

- to contribute to the quality of health services by making them more responsive to the needs and preferences of users; and
- to ensure that users have the knowledge, skills and support to enable them to influence NHS service policy and planning.

4.129 To support this the NHS Executive is planning a programme of work in four main areas:

- **culture change**, amongst health professionals about patient partnership and amongst health service staff more generally in user involvement in service development;
- the production and dissemination of **information** for health service users and their representatives;
- **structural, organisational** and **resourcing** requirements for helping patients generally and their representative organizations play a fuller part in the NHS; and
- **research and evaluation** of how best to involve patients in their own care and wider service issues.

Patient partnership work complements the NHS Executive's 1996-97 Priorities and Planning Guidance and progress will be assessed through performance management arrangements.

Patients Charter - Future Plans

4.130 Paragraphs 4.57 to 4.66 record progress to date against the Patient's Charter. Work will continue on implementing the new standards introduced in the revised and updated Charter launched in January 1995. There will be further strengthening of the standards. From April 1996 the standard for emergency admission through an Accident and Emergency (A&E) department will be improved to a maximum of two hours.

4.131 New standards on services for children and young people will be introduced in the final version of a booklet which has been widely available for consultation. The booklet will set out the way the Patient's Charter applies to services for children and young people and is aimed at parents, carers and children and young people themselves. The new standards are expected to include:

- parent-held child health records;
- being given the name and information about the child's health visitor, school nurse and paediatric nurse (in both hospital and community);
- local standards for maximum wait for first outpatient appointment for a child referred to a non-consultant led clinic;
- children to see the paediatric ward before admission and adolescents to be asked whether they want admission there or to an adult ward;
- parents to be encouraged to stay in hospital with their children and be involved in the care;
- information about pain relief; and
- play and educational facilities.

NHS Performance Tables

4.132 The third set of NHS Performance Tables are due to be published in early summer 1996. The tables will be expanded to include more information about inpatient and ouptatient waiting times and will introduce data on cervical cytology screening and vaccination and immunisation rates for the first time. The Department is looking to expand the information included in the tables in future years.

NHS Complaints procedures

4.133 New NHS Complaints procedures will be implemented from 1 April 1996. These will provide a faster, more effective and fairer service for complainants and staff alike. The aim is both to satisfy complainants and allow the NHS as a whole to learn broader quality improvement lessons. The emphasis will be primarily on **local resolution** - that is allowing NHS Trust and FHS practice staff to sort matters out quickly, responsively and flexibly. But, if this cannot be achieved, a new system of **independent review** will ensure that in appropriate cases all complaints receive a senior level review with independent key input aided by specialist assessors in cases involving clinical judgement.

4.134 The **Health Service Commissioner** will be the apex of the complaints process. He is independent of both the NHS and Government. Legislation has been introduced to widen his jurisdiction to include complaints about clinical judgement and family health services.

- **Ensure effective partnership between the NHS and other providers and purchasers of care to meet the needs for continuing care of the elderly, disabled and vulnerable people in the community**

Community care

4.135 Since the introduction of the community care arrangements in April 1993 the NHS has had a key role in supporting local authorities in meeting the objectives of the Government's community care policy. This has included joint work in respect of:

- the integration of hospital discharge and assessment arrangements;
- the agreement of respective responsibilities for continuing care;
- the contribution of community health services to supporting elderly, disabled or vulnerable people in their own homes or in other homely settings in the community.

Chapter 5, paragraphs 5.26 to 5.39 report on social services activity on community care.

4.136 The interface between the NHS and social services has been an important theme of joint monitoring of the community care changes carried out by regional health authorities (RHAs) and Social Services Inspectorate (SSI). This has indicated:

- in general a significant improvement in the **quality of joint work** between health and local authorities;
- an anecdotal shift in the **intensity** of community health services workload reflecting perhaps a greater number of more dependent people in the community as a result of the community care changes and earlier hospital discharge. From 1995-96 an attempt is being made to quantify this; and
- an on-going need for effective communication between health and social services staff over arrangements for people who need continuing care after a spell in hospital. The NHS Executive will continue to monitor the extent of delays in hospital discharges carefully. Delays in discharge can reflect a variety of circumstances for instance patients exercising their right under the Direction on Choice to enter a care home of their own choice.

Guidance on NHS responsibilities for meeting continuing health care needs

4.137 An important priority for the NHS during the year has been that of responsibilities for continuing health care. Responding to a special report published by the Health Service Commissioner, Ministers issued in February 1995 guidance on NHS responsibilities for meeting continuing health care needs. This guidance required health authorities, in consultation with local authorities and other interests and taking account of the national framework set out in the guidance:

- to review their existing commitments on continuing health care and to take action to address any significant gaps in services; and
- to develop and publish local policies and eligibility criteria for continuing health care which set out clearly the basis on which decisions on individual cases would be taken.

4.138 The objectives of the guidance are:

- to confirm and clarify NHS responsibilities for meeting a full range of needs for continuing health care;
- to ensure significant gaps in NHS services are addressed;
- to achieve greater consistency across the country in arrangements for continuing health care recognising that arrangements currently vary considerably between different parts of the country;
- to bring about greater openness and consistency in how decisions about continuing care needs are taken through publication of eligibility criteria, better information about how decisions will be taken, and the existence of a review procedure for patients being discharged from hospital who consider that a health authority's eligibility criteria have not been correctly applied; and
- to secure further improvements in the quality of hospital discharge procedures for people needing continuing care.

4.139 The guidance highlights the need for health authorities to purchase a full range of services to meet needs for continuing health care. This includes not only continuing inpatient care but also other important services such as rehabilitation, specialist support and equipment for people outside hospital and community health services for people with continuing needs. It will be important that health authorities review the balance of services they purchase. In particular there will be a need to ensure that good quality rehabilitation services are in place so that opportunities for recovery are maximised and unnecessary long term care placements or hospital readmissions minimised.

4.140 Health authorities issued draft policies and eligibility criteria for public consultation in September 1995. These must be finalised and put into operation in April 1996. Regional Offices of the NHS Executive and SSI have been monitoring closely the progress being made by health authorities to ensure that the requirements of the guidance are delivered and in particular that local eligibility criteria are in line with the national framework set out in the guidance.

- **Develop a primary care-led NHS where decisions about health care involve patients and their carers and are taken as close to patients as possible**

Developing primary care

4.141 The aim of a "primary care led NHS" is to:

- enhance the influence GPs and their teams exercise over primary and secondary care in order to improve the links between those services and make them more responsive to the individual patient; and
- further develop the quality and range of services provided in a primary care setting,

so that the NHS meets four objectives:

- delivery of high quality care
- responsiveness to the needs of patients
- co-ordinated/coherent services
- value for money.

4.142 These can best be achieved when decisions are being taken close to patients, and in general when services are being delivered close to patients' homes. There are implications for all primary care professionals, not just GPs.

Main Elements of Approach

4.143 A number of main strands of work are underway, as well as those outlined in paragraph 4.92 to 4.116, to ensure that these objectives can be achieved.

Stronger GP involvement in purchasing

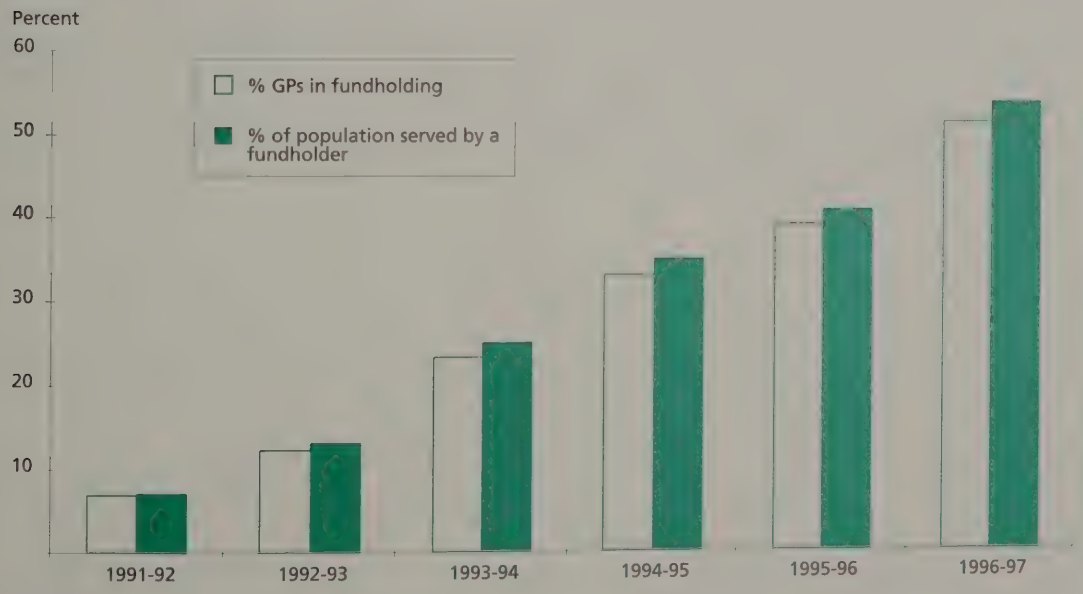
4.144 Central to a primary care-led NHS will be the further development of GP fundholding. New expanded options for GP fundholding come into effect from 1 April 1996. These include:

- **community fundholding**: a new option for small practices with 3,000 or more patients, covering staff, drugs, diagnostic tests and most community health services (excluding mental illness and learning disability services);
- **standard fundholding**: an expanded version of the existing scheme covering virtually all outpatient, elective surgical services and community health services, with a reduced list size requirement of 5,000;
- **total purchasing pilots**: where existing fundholders in a locality purchase all hospital and community health services on behalf of their patients in partnership with the local Health Authority.

4.145 By April 1996, it is expected that over half of all GPs in England (covering around 53 per cent of the population) will have taken on the responsibility of managing a fund (see **Figure 29**). Further work to develop fundholding during 1996 includes:

- an expansion of the total purchasing pilot sites from 51 to around 70;
- pilots to test the inclusion of mental health inpatient services, osteopathy, chiropractic, maternity and non-A&E emergency services within the scheme.

Figure 28 - Increase of fundholding population coverage and number of GPs from April 1991



Source: regional offices

4.146 Paragraph 4.9 highlights the clearer role that new health authorities will have and particularly their support for GPs as both providers and purchasers of health care.

Stronger Relationships

4.147 The move towards a primary care led NHS will require stronger partnerships between all parts of the NHS at local level. This will require changes in attitude and responsibility as well as skills. Although much of this can only take place within the service, local efforts will be supported by:

- a national steering group which is looking at the development needs of health authorities, NHS trusts and primary care itself, to identify what those needs are and establish what needs to be done throughout the NHS to achieve the changes required;
- the development of information and information systems to facilitate the exchange of information between general practices, NHS Trusts and Health Authorities;
- the implementation and national review of the Accountability Framework for GP Fundholding which provides a basis for stronger partnership between Health Authorities and GPs;
- enhanced management of financial risk, and strengthened cash management, through collaboration between health authorities and GP fundholders;
- improved budget-setting for fundholding practices, building on improvements in health authority resource allocation methods and on the partnerships between practices and health authorities; and
- further clarifying roles and relationships between primary care professionals and social care agencies.

Development of the primary care infrastructure

4.148 A sound base is important for the future development of primary care. The Department is taking specific action to address issues of GP recruitment and retention and of service quality in inner London, where primary care provision has historically been weaker than elsewhere. A two-part package of initiatives for London GPs has been introduced this year. The first part offers new educational opportunities for London GPs which include undergraduate teaching in the community; programmes of professional development; new educational and research fellowships and honorary lecturer posts; and extended periods of training in general practice, as opposed to a hospital setting. The second part comprises four new incentive allowances for small practices to support improvements in practice organisation and the delivery of patient care, and to attract new doctors into the capital. Many of these initiatives are being piloted for the first time in London, and the overall success of the scheme will be evaluated.

The "listening" programme

4.149 The Department is considering carefully:

- the characteristics of a primary care service; and
- the issues that need to be addressed to develop this kind of service

in order to underpin the future development of a primary care service which will continue to meet the objectives of a primary care-led NHS.

4.150 For example, in order for GPs to be able to act as co-ordinators of all health services for their patients, there must be a good supply of high quality doctors, the right skill mix within primary health care teams, the right structure to encourage productive partnerships between professionals, and the ability to match services to local needs.

4.151 In October 1995, the Secretary of State launched a debate on the future of primary care. As part of this, a wide ranging "listening programme" is taking place between January and the end of March. This is aimed at a broad range of stakeholders in primary care so that a clear view can be reached on the range, shape and characteristics of the services patients might receive in the future; and to identify the key barriers to the delivery of such a service.

4.152 This process will encompass both views from national and local levels and the Minister for Health is visiting each Region to "listen" at first hand. Once this has been completed the Department will be able to explore the options for developing the legal, financial and organisational frameworks underpinning primary care.

- **Ensure people with mental health problems are provided with a comprehensive range of secure, residential, in-patient and community services in the most appropriate setting in accordance with their needs**

Introduction

4.153 Health Authority plans for the development of comprehensive local mental health services were reviewed by Regional Offices at the request of the Secretary of State. Whilst there is clear evidence of progress and achievement, and the prospect of further improvement in 1996-97, there needs to be commitment at all levels to ensure services are local, and comprehensive.

4.154 Recent progress on mental health services include:

- a reduction in suicide rates, one of the Health of the Nation targets;
- the publication of the first national psychiatric morbidity study;
- implementation of the Care Programme Approach, which has been fully achieved in all but a handful of districts, and of Supervision Registers, underpinning the focus of specialist services on those with severe mental illness;
- the successful passage of the Mental Health (Patients in the Community) Act, which will be implemented on 1 April 1996, and completes the Ten Point Plan;
- the publication of "Building Bridges", the interagency guide on the care of people with mental illness.

4.155 But further progress is needed and priorities for 1996-97 include:

- the consolidation of adequately resourced comprehensive local mental health services for all those with severe mental illness, including mentally disordered offenders, older people and children and adolescents;
- tackling a range of workforce issues - recruitment and retention, education and training, team development and support, and management and support;
- developing the capacity of the primary care team to care for people with more common mental health problems, such as anxiety and depression and to work with the specialist teams to support those with severe mental illness and their carers;
- building the information systems which will help clinical practice, enable service delivery and development, and provide the basis for contracting, commissioning and performance management.

Health of the Nation

Suicide targets

4.156 Good progress is being made towards the Health of the Nation target of reducing the overall rate of suicide by 15 per cent by the year 2000 (see also paragraph 3.14 and table 7). Work to maintain the downward trend in the suicide rate will continue on the established themes of improving mental health services, increasing public awareness, targeting occupational and demographic groups at particular risk of suicide, and reducing access to means.

Challenge Fund and the Mental Illness Specific Grant

4.157 On 30 November 1995 the Secretary of State launched a Mental Health Challenge Fund, committing £10 million to match £10 million from the NHS.

4.158 The MISG remains an important catalyst for the development of community care for mentally ill people and has greatly improved joint planning between health and social services. An addition al £11 million will be made available in 1996-97 - an increase of 23 per cent - with a further increase of £9 million planned for 1997-98. Some of this additional resource will form a "Target Fund" which will be directed to parts of the country where there is evidence that some special help is needed to secure fully co-ordinated services for mentally ill people. The Target Fund will complement the Mental Health Challenge Fund.

Building Comprehensive Local Services

Ministerial Review of Health Authority Plans for Mental Health

4.159 At the request of the Secretary of State, the Minister of Health, wrote on 24 August to the Chairmen of Health Authorities and NHS Trusts. NHS Executive Regional Directors were asked to report on whether health authorities had practicable and deliverable plans to ensure that adequate services for severely mentally ill people were in place and, in cases where they were not, what steps would be taken to ensure that adequate plans were developed. The Secretary of State published a review of Mental Health Services by Health Authorities in England on 20 February setting out an analysis of the overview reports provided by NHS Executive regional directors.

4.160 Local comprehensive services comprise a range of care inputs including acute beds, 24 hour nursed care for new, long stay clients, hostels and supported housing, day care and occupational rehabilitation, together with appropriately trained health and social care professionals. On 20 February the Secretary of State published 'The Spectrum of Care - Local services for People with Mental Health Problems' which supplements the guidance on the components of a comprehensive local mental health service set out in the Key Area Handbook on Mental Health; and a report on 24 hour nursed care for people with severe and enduring mental illness which describes the importance of 24 hour nurse staffed accommodation as one important component of comprehensive mental health services.

Care Programme Approach (CPA)

4.161 The Care Programme Approach (CPA) is one of the cornerstones of the Government's mental health policy. It provides a framework of care to ensure the co-ordination and review of care and treatment. By the end of 1995-96 the CPA will have been fully implemented in all but a handful of districts. The NHS Priorities and Planning Guidance for 1996-97 requires health authorities to build on implementation of the CPA by ensuring that there is regular audit of the outcome of the Approach. On 20 February the Secretary of State launched an Audit Pack for the Care Programme Approach to provide commissioning agencies and providers with an audit tool. This links with the wider development of clinical audit within the NHS and supplements Building Bridges.

Mental Health (Patients in the Community) Act 1995

4.162 The main purpose of this Act is to introduce from 1 April 1996 a new power of after-care under supervision (or "supervised discharge"). This is aimed at a small number of patients who have been detained under the Mental Health Act 1983 and are ready for discharge from hospital but, because of the risk they might present to themselves or others if they did not receive after-care, warrant special, legally framed supervision to live safely in the community.

Development of Secure Services

4.163 Rapid development of secure psychiatric services, largely supported through targeted capital and revenue, has continued over the past year. By the end of 1996-97 1200 purpose built medium secure places will have been made available through the central capital programme, a further 300 secure places are being developed through the main NHS capital programme.

4.164 Changes in the management and funding of high security psychiatric services were announced in July 1995. The changes are detailed in Annex H.

Mental Health and Patient's Charter

4.165 The Secretary of State issued for consultation on 20 February a booklet containing Charter Standards for mental health. The Charter sets out what users and carers can expect from NHS Mental Health Services.

The Homeless Mentally Ill Initiative (HMII)

4.166 The HMII aims to reintroduce homeless mentally ill people in central London to mainstream services by providing multi disciplinary community psychiatric outreach teams and high quality, high care rehabilitation hostels where they can receive suitable care and support with the long term aim that they move into more permanent accommodation in the community. Over £20 million has been allocated by the Department to the HMII so far and a further £2 million per year will be made available from 1996-97 as part of the Mental Illness Specific Grant to provide additional help both in London and beyond.

Young People and Older People

Child and Adolescent Mental Health Services

4.167 The profile of child and adolescent mental health was raised considerably in 1995-96 with the publication of a Health of the Nation handbook (DH, 1995) and a Thematic Review by the Health Advisory Service. The two documents set out a new vision for commissioning and delivering these services which was based on effective joint working between the health, social services and education sectors.

Elderly Mentally Ill People

4.168 The Department recognises that a multi-agency approach is needed to plan and deliver a wide range of health, social, voluntary and financial care services for what will be a growing proportion of the population. With this in mind, the Department has already started to put together a package of measures to help the various agencies in this task. This includes commissioning the Health Advisory Service to review the services for elderly mentally ill people; help for primary care to include training materials and information for general practitioners; publication of a health needs assessment review; production of information materials to the public and purchasers; and specific financial support to both the voluntary sector and local authorities.

Mental Health and the Primary Care led NHS

4.169 The vast majority of mental health problems are encountered and treated in primary care. Work will continue to improve the detection and management of mental illness in this setting, and to encourage closer links between primary health care teams and specialist psychiatric services. A number of developmental projects are nearing completion and will inform this work.

A Knowledge Based Service

OPCS Surveys

4.170 Mental health research scientists in Great Britain have played a leading role in developing reliable methods for measuring mental health problems, using population surveys carried out by the OPCS. The information these surveys contain will help the NHS and Social Services to assess the population's mental health and social care needs and plan services accordingly.

Mental Health Research Initiative (MHRI)

4.171 The MHRI is the first time that funds within the policy research programme have been set aside specifically for mental health research; £2.4 million over 5 years. It complements work concerning mental health services commissioned under the NHS R&D National Programme in mental health and by individual regions.

Working with Users and Carers

4.172 A **Mental Health User Group** was established by the Department earlier this year to follow up some of the work of the Mental Health Task Force. The Group, which is made up of service users and representatives of the voluntary and statutory sectors, aims to look primarily at the evaluation of mental health services, training and advocacy from a user perspective.

- **Improve the cost effectiveness of NHS services, through formulating decisions on the basis of information about clinical effectiveness**

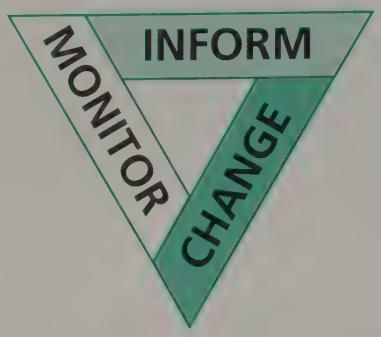
Introduction

4.173 Science and research are providing increasing information about which treatments work best. The Department and the NHS Executive are committed to ensuring this knowledge is applied in practice to improve outcomes for patients. The most effective health services must reflect an up-to-date understanding of our research knowledge. Making informed choices that deliver the best outcomes is the key component of quality for individual patients and their clinicians, and it has now become a central issue for health authorities and for the NHS Executive.

4.174 Clinical effectiveness means selecting clinical interventions for a patient (or for a population) that do what they are intended to do - ie maintain and improve health. Professional and public interest in effectiveness has been augmented by the enormous increases in the availability of research-based information.

4.175 Improved effectiveness depends upon changes in the behaviour of clinicians, patients and managers across the NHS. Securing this change requires three important ingredients.

- There must be sufficient **information** on effectiveness, and it must be made available within the NHS in a way that is accessible and useful to the many stakeholders (clinicians, patients and managers).
- Local and national action must stimulate these stakeholders into using this information in their routine practice so that it can help **change clinical and managerial behaviour**.
- The NHS must be able to **monitor** and demonstrate real improvements in the quality, effectiveness and cost effectiveness of health care.



Provide information on effectiveness
Promote change in behaviour
Monitoring impact on care

Effectiveness information and the R&D Strategy

4.176 The NHS R&D strategy has a key role to play in the move towards **evidence-based health care**, which encourages health practitioners to question their practices, convert information needs into answerable questions, and track down the best evidence to answer these questions.

4.177 In 1995-96 spending on centrally funded NHS R&D rose to around £16 million. To date over 250 studies have been funded in areas including mental health; cancer; cardiovascular disease and stroke; the interface between primary and secondary care; and physical and complex disabilities. New programmes coming onstream include mother and child health; dentistry; and asthma management. Health technology assessment (HTA) forms the largest single body of research within the NHS R&D programme, and has generated considerable interest in this country and internationally. This programme includes the evaluation of new technologies, as well as the rigorous assessment of existing ones. A new National Forum has been established to improve liaison and complementarity of programmes with other major research funders, including the charities and industry.

4.178 An R&D Information Systems strategy (ISS) has been established to bring information about R&D findings to the attention of decision-makers. Two major centres have been established: the UK Cochrane Centre and the NHS Centre for Reviews and Dissemination, which are providing decision makers in the NHS with high quality, systematic reviews of the findings from research in attractive "user-friendly" formats. The launch this year of the Cochrane Database of Systematic Reviews, and a new publication, "Effectiveness Matters", are important additions to the dissemination of knowledge.

4.179 In October 1995 the Secretary of State for Health welcomed over 1,000 delegates from 40 countries to the first international conference on the scientific basis of health services. He emphasised the dramatic rise of scientific medicine in the last half century and the importance of strong links between science and health care to ensure the outputs of science and technology are used to best effect to improve patient care.

Changing behaviour

4.180 Practitioners in the NHS are being encouraged and supported as they seek to take on board the clinical consequences of research findings. Effective Health Care Bulletins translate reviews of research into clear clinical messages using a crisp but thorough leaflet style (ten have been issued so far). Health Needs Assessments provide comprehensive information for purchasers on the likely needs of populations for clinical services (twenty issued so far with a second series in production). The NHS Executive is supporting a partnership with professional and academic bodies in the development of new clinical practice guidelines and clinical education which are founded in research evidence.

4.181 The NHS Executive has funded innovative methods of improving effectiveness, including the "Framework for Appropriate Care Throughout Sheffield" (FACTS) project in GP surgeries in Sheffield, and the launch of the nationwide "Promoting Action on Clinical Effectiveness" (PACE) programme of effectiveness projects in partnership with the King's Fund. Several other means of deploying cost effectiveness information are being explored, such as the exploitation of the new possibilities made available by clinical computer systems and electronic networks.

4.182 A centrally-funded research programme will evaluate the effectiveness of interventions to change behaviour.

4.183 All NHS purchasers are required to demonstrate improvements in the effectiveness of services, in particular within the key areas of The Health of the Nation strategy. Executive Letters on clinical effectiveness give health authorities the source of new work on clinical guidelines, Effective Health Care Bulletins and the Health Technology Assessment Programme. The most recent (EL(95)105 "Improving the effectiveness of clinical services") was published in December 1995.

Clinical Audit

4.184 Changing clinical practice relies upon sustained, coordinated and constructive peer pressure. Clinical audit provides the most powerful tool for targeting this effort. Clinical audit is increasingly becoming accepted as a prerequisite of good quality professional practice - a major achievement which has been acknowledged in the recent report by the National Audit Office. A National Centre for Clinical Audit has been opened to spread and promote best practice gained from local initiatives and experiences in audit.

4.185 Professional and academic bodies have made clear their commitment to promoting clinical effectiveness. The Department and the NHS have established good working relationships with the clinical professions which acknowledge a shared interest in effectiveness.

4.186 There is extensive evaluation work in hand on clinical audit including two projects that are nearing completion on evaluating process and outcomes of medical and clinical audit programmes. In addition to these arrangements for determining the returns from the funds made available to promote and support clinical audit, new management arrangements have been put in place to reflect the changing nature of management in the NHS. From 1 April 1996, the new unitary health authorities will become responsible for the provision of clinical audit in the work place, in multi-professional settings. From the same date the eight regional offices of the NHS Executive will be responsible for monitoring the performance of health authorities in the discharge of their clinical audit functions and responsibilities.

Patients and primary care

4.187 Further work will support the increasingly important role of patients and their primary care practitioners in influencing clinical choice and the effectiveness of NHS services.

Monitoring change

4.188 A wide range of data is available on patterns of care but this has not previously been used to monitor local and national changes in clinical effectiveness. In some parts of the country there are wide variations in care which cannot be easily explained by population characteristics. Methods are being developed to support the use of such data for highlighting questions of clinical effectiveness. These types of information will allow the NHS Executive to work with the service on the most important areas of local concern.

'Promoting Clinical Effectiveness'

4.189 A booklet 'Promoting Clinical Effectiveness' has been developed to support the work of all those involved in identifying and reviewing the effectiveness of clinical services in the NHS. The booklet was launched by the Secretary of State on 10 January 1996, supported by leading figures from the Medical Royal Colleges.

● Ensure effective management of people

4.190 Policy on staffing the NHS, Equal Opportunities and pay are geared to providing an effectively trained and skilled workforce to deliver patient care. The main current developments in human resources are described below.

Medical Education and Workforce Planning

4.191 The Department's medical staffing policies aim to ensure an adequate supply of appropriately-trained doctors to provide cost-effective, high quality patient care. The Advisory Group on Medical Education, Training and Staffing has been set up to provide co-ordinated advice from the profession and from NHS management on medical education and staffing issues. NHS employers are taking an increasing role in medical workforce planning, whilst the Government continues to maintain a strategic overview to ensure that there are sufficient doctors nationally.

The Medical Workforce

4.192 In June 1995, Government accepted the Medical Workforce Standing Advisory Committee's recommendations that there should be a gradual increase in numbers of medical students from 1996, to arrive at a maximum annual target intake of 4,970 by the year 2000.

4.193 Flexible working and training schemes set up as part of equal opportunities policy have enabled more than 1,100 hospital doctors to work part-time. This has aided the continuation and development of their professional careers and may in some instances have prevented their loss to the service.

4.194 In autumn 1995 a series of regional conferences introduced proposals for a new approach to medical staffing policy, reflecting the roles and responsibilities of Trusts and purchasers. This will provide a framework for the effective implementation of the move towards a consultant-based service, with an increasing proportion of care delivered by fully-trained doctors, together with continuing progress on the New Deal on junior doctors' working hours and the implementation of the specialist training reforms.

Reforms of specialist medical training

4.195 During 1995 significant progress was made with the implementation of the specialist training reforms, designed both to meet the UK's responsibilities under the European Medical Directive and to improve the quality of higher specialist medical education. The legislative framework took effect in January 1996.

4.196 The new Specialist Registrar grade was introduced in December 1995, following the publication of detailed and comprehensive guidance.The grade was implemented in two vanguard specialties - general surgery and diagnostic radiology - on 1 December. The aim is to publish new pay rates and terms and conditions of service before April 1996 when the majority of specialties will begin transition to the new grade.

Non-medical workforce planning

4.197 A new approach to education and training has been implemented in response to the abolition of Regional Health Authorities (see para 4.7). Under this approach, consortia of NHS Trusts and health care purchasers, and regional education and development groups (REDGs) have been established. These consortia will help to secure a more responsive employer led approach to workforce planning and education, with health care purchasers guiding local strategic direction. The new framework will be increasingly helpful in addressing a range of education issues and taking account of national priorities and wider trends in health and social care. The NHS Executive will continue to provide a national overview of workforce supply and the national framework of priorities.

Equal Opportunities

4.198 **Opportunity 2000** - There has been a comprehensive review to assess NHS performance on the goals for 31 December 1994. Achievements include:

- women were appointed to 38 per cent (ie 83 out of 214) Chief Executive/General manager posts in the 33 month period to 31 December 1994;
- 28 per cent of these posts are now held by women representing an increase of 10 per cent in the five year period from September 1989 to December 1994;
- the number of women Directors of Finance has almost quadrupled, rising from 23 in December 1992 to 84 at 31 December 1994;
- 38.1 per cent of non-executive appointments are filled by women exceeding the 1994 goal of 35 per cent and the number of women chairing NHS Trusts and Authorities was 30.4 per cent at 1 April 1995; and
- the number of women consultants increased by 5 per cent (from 13 per cent in 1984 to 18 per cent in 1994) Although overall progress falls short of the target, increased numbers of women in the junior grades suggest that this percentage is set to rise

4.199 Building on these successes Ministers have agreed to a new set of Opportunity 2000 goals in the NHS for achievement by 30 September 1998, linking the target date to the dates for collection of national workforce data to avoid duplication of effort.

4.200 **Ethnic Minority Staff in the NHS: a Programme of Action** - implementation of the Programme to promote equality of employment opportunity and to achieve fair representation of ethnic minority staff at all levels has continued. The eight goals for NHS employers to achieve cover recruitment, promotion, racial harassment, appointments to NHS boards, service delivery and training. The programme encourages positive action, not positive discrimination. Selection and promotion must be on merit only.

4.201 £250,000 per annum was allocated in 1994-5 and 1995-96 to support NHS employers and about twenty projects were approved, including management development for ethnic minority staff, encouraging ethnic minorities into the speech therapy profession, and developing an equal opportunities training package for primary care staff. The NHS Executive will continue to monitor centrally to ensure that progress towards the goals is built into NHS employers' mainstream business planning.

4.202 **Disability** -The NHS Executive is a corporate member of the Employers' Forum on Disability, an organisation of private and public sector employers keen to promote good practice in the employment of people with disabilities. An informal advisory group of NHS managers, practitioners and others interested in disability and employment issues was convened by the Executive in June 1994. The Group is advising on the preparation of a Guide for NHS Managers on good practice in the employment of people with disabilities in the NHS.

4.203 In addition, the NHS Executive has agreed to fund two seminars for undergraduates and careers advisors, plus "role model" publicity, designed to attract high calibre disabled candidates to the fast - track NHS Management Training Scheme. The Employment Service and the NHS Executive have held the first two of a series of regional seminars for NHS managers on employing disabled staff.

Developments in Pay Flexibility

4.204 Government accepted the independent NHS Review Bodies' recommendations for 1995-96 in full. The move to local pay was given a further strong steer in recommendations from the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine (NPRB). There have been the following developments during 1995:

- A new system of distinction award discretionary points establishes the principle of local pay involvement over this aspect of doctors' and dentists' remuneration.

- Agreement was reached on 4 September 1995 between NHS Executive, employers' organisations and unions/professional bodies and on 24 October at a meeting of the Nursing and Midwives Negotiating Council, on a package of proposals, which pave the way for local settlements to be reached. The principle and practice of local pay was accepted cementing local pay flexibility in the NHS for staff who retain national terms and conditions.

- Basic salaries for staff employed by Trusts increased by 1 per cent effective from 1 April 1995 and the nationally-determined increase to basic rates for NHS staff not employed in trusts by 2.5 per cent. Additional increases will be negotiated locally and agreement reached annually on the amount to be consolidated in the national scales to form base for following year.

The New Pay System : Local Pay Within a National Framework

4.205 For Trust staff retaining national terms and conditions, pay settlements above the national increase will need to be negotiated locally. Information on the outcome of local settlements will be collected using existing mechanisms. Negotiations between Management and Staff Sides will determine what increases to give consolidated national scales which will form the base for following year.

4.206 Regular meetings will be held between NHS Executive, employers' organisations and trade unions/professional organisations to discuss aspects of personnel management and policy issues.

4.207 **Review Body Evidence 1996-97** The Government's evidence to the pay Review Bodies made clear that the continuing approach to public sector pay in 1996-97 is that any increases in pay should be offset, or more than offset, by increased efficiency and other economies. This approach allows flexibility to apply different arrangements to different groups. The Health Departments' evidence to NHS Review Bodies made clear that continued moderation in pay in 1996-97 was essential. Evidence to the Nurses Pay Review Bodies sought a minimal increase in national pay rates so as to consolidate the continued development of local arrangements, leaving employers with maximum scope to make modest total improvements.

- **Secure sustained improvement in the effectiveness of communications with staff, the public and the media, and to enable all NHS organisations to share information in a controlled environment through implementation of the IM&T infrastructure**

NHS Communications

4.208 Public understanding and support for the NHS is essential to it delivering high quality, cost effective health services. Changes in the roles, functions and responsibilities of different parts of the NHS have put a much greater emphasis on the need for a systematic approach to communications throughout the Service.

4.209 Improving communications with staff, patients and the wider public is a shared responsibility across the whole Service. The role of the NHS Executive is to help create the climate which encourages people in the Service to develop their communications skills to make the NHS more accountable to patients and the public.

4.210 The role of communications in the NHS involves explaining its policies and strategies, justifying its actions, responding to criticism and where necessary, acknowledging its mistakes. It also involves explaining how the NHS works and making its services and decisions more accessible. It involves conveying information about health, influencing behaviour, promoting a healthy lifestyle and increasing health literacy in the population.

4.211 Communications should also help to motivate the workforce, clarifying the purpose and values of the NHS through good internal communications and linking the work of individual members of staff to the goals of the organisation.

4.212 The purpose of NHS communications is also to help create the conditions for the effective management of change by fostering an understanding of the need for change both in terms of organisational structure and in the nature of healthcare itself.

4.213 The NHS is now embarking on a coordinated programme of planning and managing communications to explain national health policy and strategy and to communicate a clear direction to the NHS. It is also encouraging communications managers and staff within the service to work closely together by supporting the development of a national professional network and active regional networks involving Trusts, health authorities and regional colleagues.

Information Management and Technology

4.214 Information Management and Technology (IM&T) is a term which covers the use and management of information and information systems. This applies to organised systems of all forms, whether based on human endeavour, paper methods or information technology. The emerging electronic world offers enormous benefits to organisations of all types. If the NHS is to gain the most from information management and information technology, and from the developments which have separated the purchaser and provider functions, the NHS as a whole must approach IM&T systematically.

Progress to date

4.215 The NHS Executive's Strategy for IM&T in the NHS was launched in December 1992 and aims to develop consistent information systems across the Service, provide more efficient communication and processing of information and support high quality, effective and responsive healthcare.

4.216 The framework at the core of the Strategy - the infrastructure - sets agreed national standards and codes. It covers NHS-wide electronic networks, a new NHS number and important aspects of security and confidentiality. The information to be handled on the NHS-wide electronic networks will range from statistical and financial data to sensitive patient information. The Executive, like others, is therefore very concerned to ensure that stringent safeguards are both in place and effectively operated by all those who use information systems. A Security Policy and Code of Connection exists to lay down rules, actions and controls which together with technical security measures will provide an appropriate level of protection against threats to the networking infrastructure.

4.217 The work and progress to date has focused on implementing the IM&T infrastructure and promulgating the necessary standards. Much of the infrastructure will be in place in 1996.

Plans to 1999

4.218 Whilst the short term priority is to get the IM&T infrastructure into place, the medium and long term priorities to 1999 are about realising the benefits and using IM&T as an engine for change. IM&T will support key business objectives such as seamless and integrated care including collaboration between primary care, community care and social services, patient empowerment and health education, developing a primary care-led NHS, more effective clinical services and more efficient and low cost transactions particularly in contracting.

4.219 The key medium term priorities relate to:

- ensuring proper computer to computer electronic data interchange truly to automate many processes eg, Clearing Service for contracting data, FHSA/GP links, GP/Hospital links, those identified in Efficiency Scrutinies and contracting transactions
- exploiting the NHS-wide electronic network to connect all NHS organisations, allowing them to exchange information freely and securely with ready access to data, research and knowledge bases
- enabling clinical systems to support clinicians by operational systems which will realise immediate benefits in terms of more responsive and higher quality healthcare
- improving data quality.

DH Internet site

4.220 The Department's Internet World Wide Web site was launched on 20 June 1995 and is amongst the most heavily used of the Government Department's home pages on the CCTA's Open Government server with some 6000 accesses per week. The site includes details of DH strategic aims and objectives, NHS developments, Research and Development activities, press releases, Departmental publications and events, progress on the Health of the Nation initiative and details of public information phone lines. To help users easily locate new information a "What's New" page lists new additions. The address of the Department's Internet site is http://www.open.gov.uk/doh/dhhome.htm and a feedback form facility is available. Further information is being added to the DH Internet site, including material on the NHS Organisation Codes and on mental health, as well as WWW links to other DH related sites including the Medicines Control Agency, Medical Devices Agency and NHS Executive Regional Offices.

5 SOCIAL CARE

Introduction

5.1 Local authority social services departments have a statutory responsibility to provide, or arrange for the provision of, social care and other personal social services to vulnerable individuals and families in a variety of different situations. They are accountable for the quality of the services they provide.

5.2 The role of the Department of Health, and specifically of the Social Care Group, is strategic. It seeks to establish a framework of national policies for delivering high quality and cost-effective services, and to provide well-focused and suitable support to local authorities in discharging their statutory responsibilities. It does so by, for example, issuing general guidance to social services authorities.

5.3 Within the Social Care Group, the Social Services Inspectorate has a special professional role. Its Inspection Division inspects social service provision and its organisation and management on behalf of the Secretary of State. Its Regional Offices help manage the Department's working relationships with local authorities and independent service providers. They monitor and support the implementation of government policy for the Personal Social Services and provide advice to both national and local government across the full range of professional, management and policy issues. Provision for the objectives in this chapter appears in the 1996-97 Main Estimate for Class XI, Vote 2.

5.4 The current key objectives of the Social Care Group are to support local authorities and voluntary and private providers in conjunction with other partner agencies by:

- assessing services and trends in service provision through inspection and other measures, encouraging realistic improvements in effectiveness and efficiency and in the professionalism of social service personnel;
- in community care, encouraging the fuller achievement of the objectives of the 1993 reforms and the development of social care for mentally ill people and other vulnerable groups;
- in services for children, encouraging the reinforcement of family support and the protection of children and young people, strengthening social care for young offenders and those at risk of offending, and developing adoption services and working towards the modernisation of adoption laws; and
- in the regulation of social services, working towards a more consistent and effective framework.

Management and Resources

Funding arrangements

5.5 The level of Standard Spending is set annually and represents what the Government believes it is appropriate for local authorities to spend on their services. For the purposes of allocating Government support to local authorities, Standard Spending is assumed to comprise a standard income from Council Tax, a share of Non Domestic Rate, and a share of Revenue Support Grant. However, authorities are not bound to spend this amount. It is for them to decide exactly how much to spend in the light of local priorities and circumstances. They may, within limits, vary Council Tax, spending from reserves and other sources.

Distribution

5.6 Total Standard Spending for Personal Social Services comprises the standard spending assessment (SSA) control total, and special and specific grants. The control total, which covers the bulk of local authorities' revenue resources, is distributed between local authorities on the basis of formulae which take account of measures of relative need for social services. The SSA formula is divided into four elements (residential care services for older people, domiciliary services for older people, children's services, and other services for adults) and different indicators of "need to spend" are used for each element. Examples of the factors used in the formulae are:

- Age
- Number of people on income support
- Number of older people with long standing illnesses
- Number of children from lone parent families
- Number of homeless families with children

5.7 The factors used in the allocation formulae are reviewed each year. No major changes were made to the formulae used for the 1996-97 distribution. The data used in the formulae were however updated to take account of the latest information.

5.8 For the first four years of the new community care arrangements (1993-94 to 1996-97), the Government has established a Special Transitional Grant (STG) which is a ringfenced grant which can only be spent on community care services. The STG consists of new resources each year with the previous year's STG being distributed through the Revenue Support Grant. The STG is distributed using a particular combination of the SSA formulae for the elements relating to services for older people and other adults. The STG has helped to ensure that a proportion of community care finance is spent in the independent sector.

5.9 Other specific grants have been distributed in a variety of ways. The mental illness specific grant is distributed in a similar way to the Special Transitional Grant using a combination of the SSA formulae for older people and other adults. Most of the other grants are distributed by competitive bidding or are distributed by reference to the number of service recipients in the local authority area. A new special grant for unaccompanied asylum seeking children will begin in 1996-97.

Capital resources

5.10 Government provides capital resources for personal social services by means of credit approvals (permission to borrow) and a capital grant provided specifically for the development of secure accommodation for young people. Credit approvals can be either basic credit approvals (BCAs), which may be used for any local authority service, or supplementary credit approvals (SCAs), which are targeted on particular services or projects.

5.11 Local authorities are also able to finance capital expenditure by using certain receipts generated from the sale of capital assets and revenue. Capital receipts do not have to be spent on the service which generated them. Local authorities are therefore able to spend the receipts on any local priority including personal social services.

How the resources are used

5.12 The pie chart at **Figure 29** shows gross expenditure by client group in 1993-94. **Table 22** sets out in detail the figures underlying the pie chart.

5.13 Almost 50 per cent of local authorities' expenditure was on older people. The biggest single item of expenditure was residential care for older people, which accounted for 13 per cent of all gross personal social services expenditure. Although the majority of this expenditure related to residential care provided by local authorities, the balance will change in the future as the results of the community care reforms take effect and more services are purchased from the independent sector.

5.14 On children's services almost 70 per cent of expenditure involved non-residential care, most of which was the cost of social workers' time and the cost of fostering.

Figure 29 - Local Authority Gross Expenditure on Personal Social Services by Client Group 1993-94

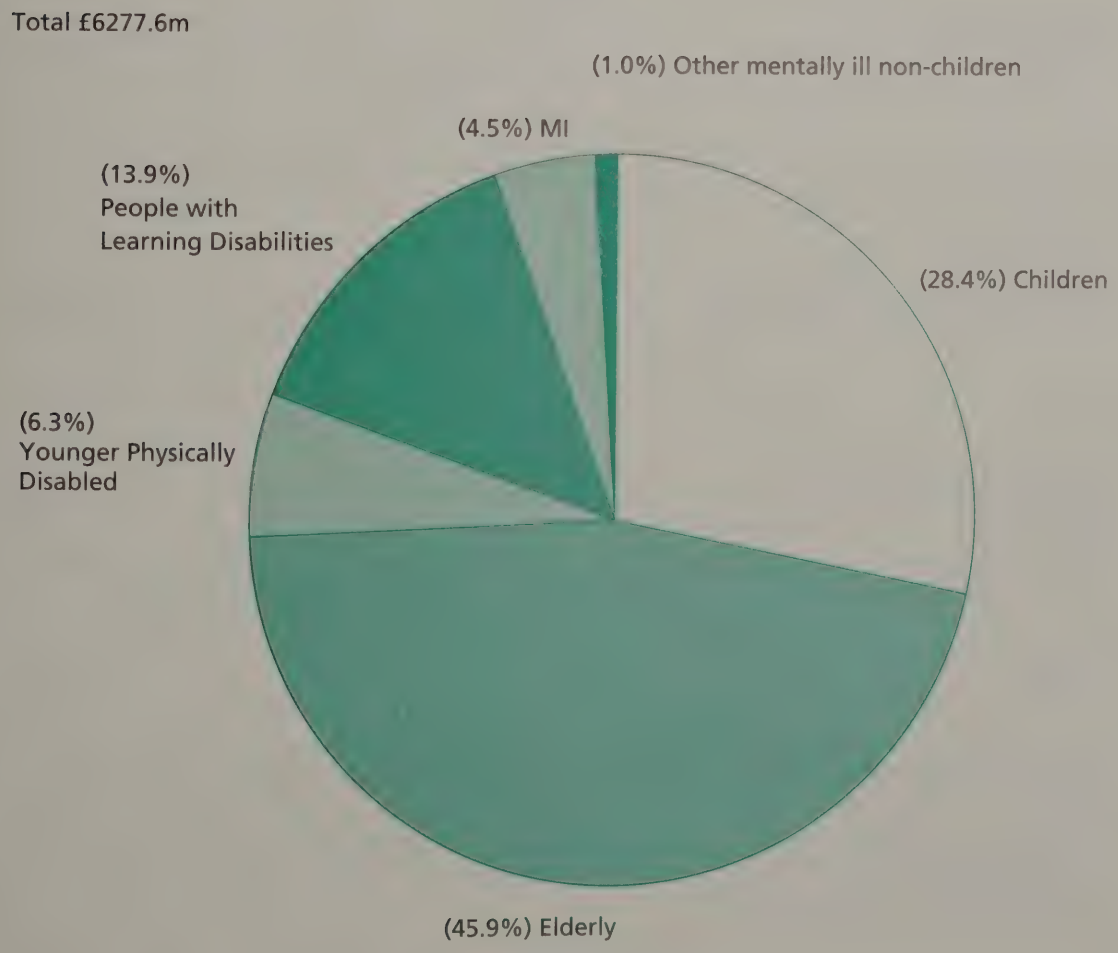


Table 22 - Client Group Related Personal Social Services Gross Expenditure

Client Group			1993-94
Children			1783.8
of which:	Residential		555.1
		Community Homes	307.2
		Voluntary & Private Childrens Homes	107.2
		Other	140.6
	Non Residential		1228.7
		Boarded Out	244.9
		Day Nurseries	125.7
		Family Centres	85.1
		Fieldwork	325.9
		Other	447.2
Elderly			**2882.3**
of which:	Residential		**1322**
		Local Authority homes for the elderly	816.7
		Placements in independent residential care	209
		Nursing Placements in independent homes	113
		Other	183.4
	Non Residential		**1560.3**
		Home care/home help service	649.8
		Day Centres	102.3
		Fieldwork	184
		Meals on Wheels	72.6
		Other	551.6
Physically Disabled			**394.1**
of which:	Residential		**147**
		Homes for Young Physically Disabled	58.8
		Other	88.2
	Non Residential		**247.1**
		Day & Occupational Therapy Centres	46.3
		Fieldwork	62.2
		Other	138.5
Learning Disabled			**871.6**
of which:	Residential		**360.6**
		Staffed & Unstaffed homes	312.7
		Other	47.9
	Non Residential		**511**
		Adult Training Centres	258
		Fieldwork	53.5
		Other	199.4
Mentally ill			**283**
of which:	Residential		**49.6**
		Staffed and unstaffed homes	39.7
		Other	9.9
	Non Residential		**233.3**
		Voluntary & Private	26.3
		Fieldwork	63.1
		Other	143.9
Other Services			**62.8**
of which:	Residential		**2**
	Non Residential		**60.8**
		Fieldwork	31
		Other	29.8
Total Services			**6277.5**
of which:	Residential		**2436.4**
	Non Residential		**3841.2**
		Of which Fieldwork	719.7

Notes
(1) Including apportioned overheads; the major expenditure items are shown under each heading
(2) Including all overheads (these cannot be apportioned to individual services within residential/non residential sections)
(3) Assumed to be all non residential

Allocations for 1996-97

Revenue resources

5.15 Personal Social Services (PSS) Standard Spending has been set at £7447 million for 1996-97. That represents an increase of 6.9 per cent over the 1995-96 level. **Table 24** shows how the total is made up.

Table 23 - Personal Social Services Standards Spending 1996-97

	£million
PSS Standard Spending	7446.5
of which:	
Standard Spending Assessments	6908.6
Special Transitional Grant for Community Care	418.0
Special Grant for unaccompanied asylum seeking children	3.0
Specific Grants	116.9
of which:	
Services for the mentally Ill	58.3
Training Support programme	35.5
Services for people with HIV/AIDS	13.7
Guardian ad litem and reporting officer service	6.3
Services for drug and alcohol misusers	2.5
Contribution to grants for projects to help meet the language needs of ethnic minorities	0.7

Figures may not sum due to rounding

5.16 In addition, there will be a special grant in 1996-97 in respect of the cost to local authorities of the increase in capital limits for the residential care means test.

Capital resources

5.17 For 1996-97 the BCAs for personal social services will be £88.6 million. Annual capital guidelines (ACGs) of £96.6 million will be distributed to local authorities for personal social services (ACGs comprise BCAs plus receipts taken into account). SCAs will be available for services for mentally ill people (£11.6 million) and for people with AIDS/HIV (£3.1 million). And a £27.2 million capital grant will be available for the provision of additional secure accommodation for children.

Staff

5.18 In 1993-94 (the latest year for which full financial year figures are available), employee costs accounted for some 60 per cent of gross current local authority spending on the social services. **Table 23** shows the staffing figures for the main PSS staffing groups. PSS staff increased by 12 per cent between 1984-85 and 1994-95. There have been significant increases in social work and day care staff.

Table 24 : Personal social services staff

'000 whole time equivalents

	1984-85	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95
Senior directing and professional staff [1]	5	6	6	7	7	8	8	9
Social work staff [2]	24	28	29	30	31	32	33	35
OT staff and assistants	1	2	2	2	2	2	3	3
Domiciliary services staff	53	60	60	60	59	58	57	58
Support services	18	20	20	21	22	22	24	26
Day Care Provision:								
Children[3]	9	10	9	9	8	8	9	9
Adult/Elderly	15	18	19	20	20	21	19	20
Mixed	1	1	1	2	1	1	2	2
Total	25	29	29	31	29	30	30	31
Residential Provision								
Children[4]	21	18	18	17	16	15	14	14
Adult/Elderly	63	69	70	69	66	63	59	58
Mixed	1	1	1	2	1	1	1	0
Total	85	88	89	88	83	79	74	72
All other staff	2	4	4	4	5	5	2	3
Grand Total	213	236	239	240	238	235	233	238

(1) Director, Deputy Director, senior management planning and (from 1993-94) and senior support staff (SO grade and above).

(2) Including team leaders/assistant team leaders and (from 1993-94) care managers.

(3) Including Family Centres, playgroups, and nursery provision where funded by Social Services

(4) Includes Community homes for children looked after, observation and assessment centres where mainly residential and special needs establishments/resource centres mainly for children

Value for Money

5.19 The responsibility for ensuring that personal social services are delivered efficiently lies with local authorities. Authorities are expected to make the most effective use possible of the resources available to them.

Unit costs

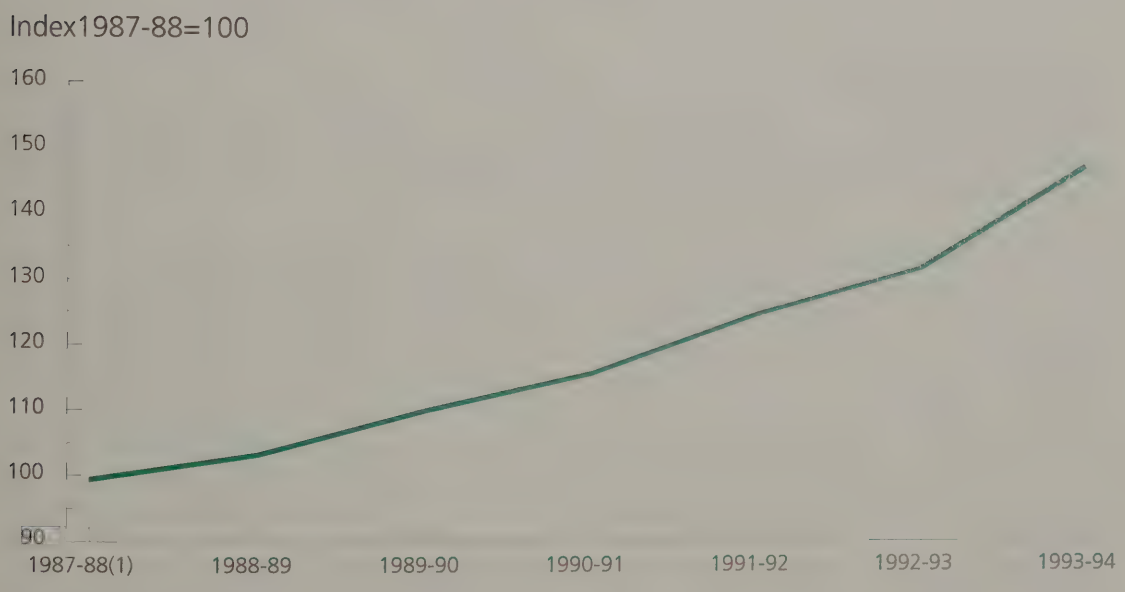
5.20 **Figure 31** shows how unit costs of local authority supported residential care for older people have risen, after allowing for movement in the GDP deflator.

This may reflect higher average dependency levels among supported residents. The proportion of older supported residents who are aged 85 and over increased from 43 to 49 per cent between 1987-88 and 1993-94, which is consistent with an increase in dependency.

5.21 The figures may also reflect improvements in the quality of care. It should be noted that local authority and independent homes have seen an increase in the provision of places in residential homes in single rooms, from 50 per cent of places in 1987-88 to 71 per cent in 1993-94. There has also been a change in the distribution of the size of homes, with a move away from larger homes (50 places and over) towards medium sized homes (30 to 49 places).

5.22 In recent years it has become increasingly difficult to match up expenditure figures with the relevant activity and staffing information reported to the Department by Local Authority Social Services. The expenditure return has therefore been substantially revised and the new form will enable much closer matching, facilitating the construction of meaningful unit costs both nationally for England and for individual authorities, in respect of PSS provision. It is expected that these new unit cost figures will be produced in 1996.

Figure 30 - Average real gross weekly expenditure on residential care for older people per supported resident



(1) 1987-88 value=£150

Efficiency

5.23 The increases in unit costs referred to above may also reflect reduced efficiency. There is also substantial variation in unit costs between authorities, raising questions about value for money. The Department has commissioned research into measures of efficiency in social services, and there is some evidence that it has in the past been declining. The Department will be pursuing the issue with local government interests and the Audit Commission.

5.24 Subject to enactment of legislation now before Parliament to provide the necessary powers, a start will be made early in 1996-97 on the new joint reviews by the Audit Commission and the Social Services Inspectorate of individual social services authorities.

Current Activity Levels

5.25 Personal social services help large numbers of people with a wide range of needs. The volume of activity within an authority may depend on a number of factors, including its demographic and socio-economic characteristics. With this important caveat, the figures below may help to give an impression of the volume of activity for a notional social services authority with a population of 200,000. Such an authority might expect to have:

- 1,000 older people in residential care
- 2,200 households receiving home help services
- 130 people with learning disabilities in residential care
- 900 attendances each week at day centres by people with learning disabilities
- 30 people with physical disabilities in residential care
- 60 attendances each week at day centres by people with physical disabilities
- 50 mentally ill people in residential care
- 150 attendances each week at day centres by mentally ill people
- 140 children on the child protection register
- 210 children looked after
- 25 children adopted each year, of whom 10 are children adopted from local authority care
- 5 new admissions of young people to secure accommodation each year.

Community care services

5.26 Government policy on community care aims to ensure that vulnerable people affected by the problems which attend ageing, mental illness, physical, sensory or learning disability or drug and alcohol misuse receive the care they need in homely surroundings.

5.27 The policy is underpinned by the White Paper "Caring for People" (1989) and the NHS and Community Care Act (1990), which became fully operational in April 1993. The Department of Health has lead responsibility for community care in England. Other Departments, particularly Environment and Social Security also have an interest. The NHS contribution is discussed in Chapter 4 at paragraphs 4.132 to 4.137.

5.28 At local level, local authorities have lead responsibility and work closely with health and housing authorities to assess needs and arrange services. Independent sector providers, users and their carers are actively involved in this process.

5.29 Community care services are now mainstream activities maintaining large numbers of people, and are delivered by local authorities through residential care, home help/care services, meal services and day care provision.

5.30 In residential care provision, the most marked trend over recent years has been the continuing increase in the number of places provided in the private and voluntary sector and corresponding fall in the numbers provided in local authorities' own homes. Independent sector homes generally have lower costs. Their use has been encouraged by the Community Care Special Transitional Grant which requires that a high proportion of each year's new community care finance should be spent in the independent sector.

5.31 Home help/care is defined as traditional home help services and services which assist the client to function as independently as possible in their own home. Services may involve routine household tasks within or outside the home, personal care of the client or respite care in support of the client's regular carers.

5.32 Statistics collected in 1994 show that the majority of home help and home care services, around 80 per cent of total contact hours covering almost 90 per cent of households receiving these services, are provided directly by local authorities. The balance is provided mainly by the private sector, with a minimal contribution by the voluntary sector. Although the level of private sector provision is relatively low, involving 9 per cent of households receiving these services, it is significantly higher than in the previous year.

5.33 Since 1992, the total number of contact hours per 10,000 households has risen by just over 31 per cent, reflecting the community care objective of increasing support in people's own homes.

5.34 For people aged 18- 64, the main client group to benefit from home help and home care services is that for people with physical and/or sensory disabilities. Households falling into this category account for 60 per cent of households in receipt of services in England as a whole.

5.35 Meal services deliver either to people's homes or to luncheon clubs. A 1994 survey showed that about 82 per cent of these meals were provided through the "meals on wheels" service to clients in their own homes, the remainder being supplied at luncheon clubs. The majority of meals provided through the "meals on wheels" service were supplied by local authorities, who account overall for about 59 per cent of total provision. For luncheon clubs, the voluntary sector was the main provider of meals, accounting overall for 55 per cent of total provision compared with 42 per cent for local authorities.

5.36 In 1994, local authority day centres accounted for almost 65 per cent of all day centres and more than 85 per cent of all day centre places. The voluntary sector operated around half as many day centres as did local authorities. The private sector made only a very small contribution to day care, accounting for less than 5 per cent of centres, and only 1 per cent of places.

5.37 In the provision of day care, younger adults (aged 16 - 64) receive a significant proportion of the services. Across the country as a whole, the number of day centres is split almost equally between those that cater primarily for older people (aged 65 and over) and those which cater primarily for younger adults. Local authority provision, in terms of available places, tends to be primarily for people aged 16 - 64 with learning disabilities and people aged 65 and over.

5.38 Local authority day centre staff are also involved in providing outreach services such as shopping and swimming. Survey results show that the main beneficiaries of such services are people aged 16 - 64 with learning disabilities.

5.39 In 1994, there was a growth of 5 per cent in local authority day centre places compared to an increase of almost 40 per cent in the independent sector. Of this increase, 65 per cent was in places for older people.

Services for older people

5.40 Most Personal Social Services provided are for older people - over 80 per cent of residential care places, for example. Almost all meals delivered to people's homes or served at luncheon clubs are for older people (800,000 during a survey week). See **Table 26**.

Table 25 - Personal Social Services for older people

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95
Local authority residential places [1]	116,100	97,900	86,700	77,000	68,900	63,800	-45
Voluntary and private residential provision	117,500	192,000	199,600	205,500	210,000	213,200	81
Local authority funded day centre places [2]	21,100	25,900	na	139,100	147,600	176,400	na
Meals delivered to people's homes/ served at luncheon clubs [3]	41.0m	45.9m	45.8m	776,700	768,400	794,100	na

(1) Figures include places in homes for elderly, elderly mentally infirm and elderly with disabilities and adults with physical and/or sensory disabilities.

(2) Figures are for local authority centres only as at 31 March up to 1990-91 and for all places funded by local authorities during a sample week since 1992-93.

(3) Annual estimate in millions to 1991-92; subsequent years are for a sample week in September/October.

Services for people with learning disabilities

5.41 The second largest client group in residential care (after older people) is people with learning disabilities. This is the largest client group for local authority funded day centre places, accounting for almost half the total. See **Table 26**.

Table 26 - Personal Social Services for people with learning disabilities

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95
Local authority residential places	15,000	16,700	16,300	15,500	14,200	12,300	-18
Voluntary and private residential provision	7,100	18,900	21,200	24,100	25,500	26,700	276
Local authority funded day centre places specific to people with learning disabilities [1]	48,800	56,700	na	139,100	259,200	268,800	na

(1) Figures are for local authority centres only as at 31 March up to 1990-91 and for all places funded by local authorities during a sample week since 1992-93.

Services for people with mental illness

5.42 As shown in **Table 27**, the number of places in residential care homes for people with mental illness has increased significantly, particularly in the private sector. There is also an increased emphasis on services provided in the community; the number of day centre places funded by local authorities has increased by a quarter in two years.

Table 27 - Personal Social Services for people with mental illness

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95
Local authority residential places [1]	4,400	7,700	7,600	7,200	6,800	6,400	47
Voluntary and private residential provision	3,200	13,200	14,700	16,100	17,000	18,400	480
Local authority funded day centre places specific to people with learning disabilities [2]	5,400	7,800	na	39,800	45,300	50,500	na

(1) Figures include places in homes for elderly mentally infirm people from 1990-91 onwards.

(2) Figures are as at 31 March up to 1990-91 and during a sample week in September/October for subsequent years.

Services for people with physical and/or sensory disabilities

5.43 The volume of Personal Social Services for people with physical and/or sensory disabilities has not changed significantly over the period, although comparisons with earlier years are complicated by changes in methods of statistical collection. See **Table 28**.

Table 28 - Personal Social Services for people with physical and/or sensory disabilities

	1984-85	1990-91	1991-92	1992-93	1993-94	1994-95	% change 1984-85 to 1994-95
Local authority residential places [1]	na	1,700	1,600	1,600	1,500	1,400	na
Voluntary and private residential provision [1]	na	6,900	6,900	7,000	7,200	6,900	na
Local authority funded day centre places specific to people with learning disabilities [2]	8,700	9,100	na	53,100	51,900	53,500	na

(1) Figures on places in homes for people with physical and/or sensory disabilities are not available separately before 1987. They were collected together with homes for older people (see table 26).

(2) Figures are for local authority centres only as at 31 March up to 1990-91 and for all places funded by local authorities during a sample week since 1992-93.

Future Plans

Community care

Community care charters

5.44 The community care reforms emphasise choice, quality and accountability. Extending the Citizens' Charter to community care is helping to ensure that users and carers are in a position to make informed choices about the kind of care they receive.

5.45 Local authorities are expected to publish their first local charters, based on the Departmental publication "A Framework for Local Community Care Charters" in April 1996. Health authorities are expected to play their full part in the development of these local charters.

5.46 These charters will give people local information about the services and standards they can expect from community care.

Community Care Plans

5.47 To coincide with the publication of their first local charters, local authorities will also publish new community care plans in April 1996 in accordance with new Departmental guidance. The new guidance "Community Care Plans from 1996-97" (LAC(95)19) helps ensure that local authorities adopt a long term strategic outlook to community care planning. It also further encourages better joint planning between social services, health and housing authorities and the full involvement of relevant local agencies in the successful delivery of high quality care.

"Building Partnerships for Success" - Community Care Development Programmes

5.48 The Department published the document, "Building Partnerships for Success" at the social services conference on 22 September 1995.

5.49 "Building Partnerships for Success" sets out the Department's programme for community care development in eight key areas:

- Building partnerships with users and carers
- More specific focus on outcomes for users and carers
- Building partnerships with other agencies
- Developing new options for service delivery
- Care management
- Management information
- Research
- Staff development

5.50 Project applications were invited for funding under the scheme and more than 300 applications were received for the first round. From these, 34 successful applications were selected which clearly supported the key development areas, demonstrated a clear focus on users and carers in a wide range of client groups and showed multi-agency collaboration.

5.51 Funding of more than £500,000 was made available for projects in 1995-96 and it is anticipated that further resources of about £1 million each year will be made available under the scheme in 1996-97 and 1997-98.

Joint Commissioning - planned workshops

5.52 Effective collaboration between the various provider agencies in the planning and delivery of community care is essential if users and their carers are to receive the efficient, co-ordinated services they deserve. The Department continues to encourage and to support such joint commissioning. Two documents were published in May 1995 - "An Introduction to Joint Commissioning" and "Practical Guidance on Joint Commissioning" - to assist health and local authorities to develop practical collaboration in planning and commissioning services.

5.53 A new series of follow-up workshops is planned for 1996. To involve users and carers (see next section) is one of the key themes for the programme, giving them greater control over the processes and services involved in community care.

Users and Carers

5.54 The Carers (Recognition and Services) Act 1995 takes effect from 1 April 1996. Under the Act, people providing or intending to provide regular and substantial care will have the right, on request, to an assessment when the local authority assesses the community care needs of the person cared for. The results of the carer assessment will be taken into account when the local authority is deciding on the services to be provided to the user.

5.55 Following consultation, the Department will be issuing policy guidance and a practice guide to local authorities on the implementation of the Act early in 1996. The guidance considers the scope of the Act and offers research-based analysis and advice to assist local authority assessments on an individual-case basis.

5.56 The guidance seeks to emphasise:

- greater recognition of carers, paying attention to and responding positively to what they say;
- an assessment of the "caring system" which considers the range of support available to users and carers;
- an integrated family-based approach; and
- improving practice, not increasing bureaucracy, by providing the opportunity for a private conversation without elaborate procedures.

5.57 More broadly, the current priorities of the Secretary of State include " to take forward issues on carers", particularly in relation to the new Act. The aims of the work planned are to empower users and carers; and to focus on outcomes and not merely on process.

5.58 The Department is also continuing its financial support to voluntary bodies concerned with carer issues.

5.59 "Caring Today" and "What Next for Carers" are two recent reports (summarised in "A Way Ahead for Carers") resulting from an SSI inspection and study of support for carers. "Caring Today" evaluated the policies and practices of social services in a sample of five local authorities against the requirement of community care legislation to support carers. The inspection stressed the value of:

- a strategic approach which informs service provision and practice,
- effective information for carers,
- assessment and care management practice and service which supports carers, and
- short term breaks for carers and a range of respite services so that individual carers' needs can be accommodated.

5.60 "What Next For Carers" investigated and assessed a number of projects and special initiatives in local authorities known to have given some priority to work with carers. It focuses on the strategic and inter-agency dimension, consultation and development. The report stresses the need for stronger health involvement and considers how effective consultation can contribute to more responsive services to carers. A series of workshops is planned for early 1996 to publicise the findings of these reports.

Young carers - continuing work

5.61 In April 1995, a letter from the Chief Inspector of Social Services drew the attention of local authorities to the particular needs of young carers and relevant local authority powers and responsibilities.

5.62 Young carers have the same assessment rights as adult carers under the Carers Act. The Carers Act guidance draws on recent work including a series of regional seminars organised by the SSI. The report of the seminars supplements the guidance by presenting different perspectives on young carers and families affected by disability or illness.

5.63 Further factfinding fieldwork, with the aim to identify and publish best practice, is being conducted by SSI. This involves interviews with LA staff and interviews with carers and their families to establish their views.

Community Care (Direct Payments) Bill

5.64 The Community Care (Direct Payments) Bill was introduced in the House of Lords on 16 November 1995. This legislation will allow local authorities to give people cash payments as an alternative to community care services. This is a new development for community care and one for which people with disabilities in particular have been pressing.

5.65 People who receive direct payments will be able to buy their own community care services, giving them more choice and control over their lives, and so more independence.

Care for adults in residential and nursing homes

5.66 The national rules for assessing the financial contribution individuals must make to the costs of their place in a residential care or nursing home when the placement is arranged by a social services department are laid down in regulations and guidance produced by the Department. These are regularly reviewed and amended when necessary, generally to maintain the link with the similar rules for claiming Income Support.

5.67 In the November 1995 Budget the Government announced that the rules for assessing the amount to be contributed by residents from their capital are to be altered, so that from April 1996 no contribution is required from capital of £10,000 or less (increasing the lower limit from £3,000), and the amount above which no assistance is available towards meeting the costs of care will be doubled to £16,000 (from £8,000). This will increase the number of people eligible for assistance with their care home fees.

5.68 The Government will also consult early in 1996 on a range of proposals to encourage people to make provision for long-term care. In particular, the Government is studying the concept of "partnership schemes", the essence of which would be that individuals who plan ahead to meet a proportion of long-term care costs themselves will be able to retain more of their assets above the £16,000 capital threshold.

Joint Strategy Group on Local Authority Occupational Therapy Services

5.69 A Joint Strategy Group has been set up to carry forward strategic issues related to the provision of Local Authority occupational therapy services. This follows Ministerial meetings with employer and professional organisations.

5.70 These issues include reviewing actions taken by local authorities to maximise use of resources and reduce waiting lists, considering the findings of the workload and recruitment and retention surveys, and promoting good practice. The Group will submit a report to Ministers in December on the further work and action needed to be taken to secure long-term improvements in the efficient and effective delivery of community occupational therapy services.

Services for Older People

5.71 The Department's policy is to promote services for older people aimed at facilitating independent living in the community. This is reflected in improvements in community nursing services and falling lengths of hospital stay. These improvements have been mirrored by the growth of local authority provision in domiciliary services predominantly used by older people.

5.72 In reviewing priorities for the NHS, the Department has placed emphasis on the need for sensitive hospital discharge practices and high quality community and rehabilitation services. Particular priority has been given to the need for individual assessment and the early detection of problems. The overall policy is to develop more integrated patterns of service for older people through joint working between all the relevant agencies.

5.73 The Department has continued to promote work on sickness and disability prevention for older people. This has included research on Healthy Life Expectancy measures, published in October 1995. An expert working group has been set up to look further at available measures of health state and possible future developments in data collection. The Department has also supported the development of health mentoring projects and other initiatives using older volunteers, and the production of advice to GPs on health promotion for older people.

Services for People with Physical Disabilities

5.74 The Department's policy for people with physical disabilities has been developed in a range of ways which also tend to address the needs of disabled people from all client groups. These include supporting disabled people's organisations in the provision of information and services, helping ensure that local authorities meet their statutory responsibilities to provide services to disabled people, and promoting the principle of independent living.

Services for people with sensory impairment

5.75 Work continues both within the Social Services Inspectorate and through policy development on services for people with sensory impairment. Draft guidelines on the provision of services for older people with dual sensory impairment were published in November 1995, with support from the Parliamentary Under Secretary of State for Community Care. The guidelines were drawn up by a working party composed of representatives from the voluntary sector, health authorities and local authorities. Fifteen local authorities have now agreed to pilot the guidelines and exchange information on aspects of good practice and two of these pilots will be carried out by a joint health authority/local authority team. Reaction to the guidelines has been positive, with support coming from the Association of Directors of Social Services and voluntary organisations in the field.

5.76 The guidelines, titled "Think Dual Sensory" have been widely circulated for consultation and it is expected that a final version will be published during the financial year 1996-97.

5.77 Funding from the Community Care Development Programme (see para 5.46) is supporting three voluntary sector projects on aspects of community care for people with sensory impairment. The projects, run by Sense, Living Options (Devon) and the Council for Advancement of Communications for Deaf People (CACDP) all involve direct consultation and liaison with users.

Services for people with mental health problems

5.78 Services for people with mental health problems are described in paragraphs 4.153 to 4.172

Services for people with learning disabilities

5.79 In 1996, which sees the 25th Anniversary of the White Paper "Better Services for the Mentally Handicapped", the Department will be continuing work on a range of topics to build on the significant progress already made in developing services which are more responsive to individual needs.

5.80 This is an area where the Department is particularly keen to develop active involvement of users and carers (see above). As part of its on-going work programme, the Social Services Inspectorate published a report in December 1995 of an inspection of leisure services "Opportunity or Knocks", the first to involve people with learning disabilities as part of the inspection team. The Social Services Inspectorate and the National Development Team are currently working jointly on a project "Partnership in Change" which considers ways of involving users and carers in service development particularly at times of change.

5.81 To assist authorities in their task of making the best use of resources in meeting the needs of the people with learning disabilities in their area, the Department has set up an independent evaluation of the cost and outcomes of various types of residential provision, including village communities. The first phase of the evaluation will be completed by 31 May 1996 and will comprise a review of relevant research literature and an analysis of readily available information on costs.

Children's Services

5.82 Policy on children's services has been influenced by two main streams of thought and activity. First there has been a continuing and growing need to use social services resources as efficiently as possible to meet the ever increasing demand to provide services for children in need. This was highlighted by the Audit Commission report "Seen But Not Heard". Secondly, a programme of research into child protection and its outcomes suggested that while the system was working effectively to protect those who were seriously at risk of harm, many needy children who were not perceived as being at risk in this way were not receiving services from which they would clearly benefit.

5.83 Working jointly with the Association of Directors and Social Services, and involving other Government departments fully in the discussions, the Department of Health concentrated, during 1995-96, on encouraging the debate around these issues and promoting some quite significant changes in the way children's services are focused.

Children's Services Plans

5.84 At the same time, and as part of the same strategy, an Order was laid in February 1996 to make the production of Children's Services Plans by Local Authorities Social Services Departments mandatory and to require them to consult with the other agencies involved, in particular health, education, the police and the main voluntary bodies. Full, but non-prescriptive, guidance was produced emphasizing the importance of assessing needs in consultation with users and of working with other agencies to meet these needs as effectively as possible. In particular, the setting of clear, quantified objectives and targeting resources to meet these objectives was emphasized. During 1996-97 further work will be done to encourage the production of better, more focused Children's Services Plans and to look at ways in which Citizen's Charter principles, and in particular consultation with users of service, can be built into plans.

5.85 The debate will be taken forward and good practice stimulated by developing networks of social services staff who can meet to exchange ideas and act as a quality network.

Child Protection

5.86 The aim will be to move steadily, and jointly with local authorities, towards an approach to children's services, drawing on the model for community care, whereby frontline staff can assess the needs of children who are referred to them and agree, jointly with other agencies, a package of care.

5.87 Children in need of protection from significant harm would be regarded, in this model, as a subset, albeit an extremely important subset, of children in need. Nevertheless, given the high priority that has to be attached to protecting vulnerable children, the Department is also continuing work to look at how best to target resources devoted to child protection. In particular, the links between adult mental health and child abuse are being explored and closer links being fostered with child and adolescent psychiatry.

5.88 The Department also continues to work closely with the Lord Chancellor's Department and the Home Office in trying to reduce the delays that children suffer when cases of child abuse are being considered by the Courts.

Children Living Away From Home

5.89 There has been an increasing emphasis on promoting the health and development of children in need within their own families. Now, only when the child's best interests cannot be assured in this way are alternative means of care and accommodation provided. This has led to a reduction in the number of children looked after and, in particular, the use of residential accommodation. It has also resulted in the use of fostering and residential care predominantly for children with more severe problems. Although increased case-severity has resulted in increased unit costs for residential and fostering services, these increases need to be understood in the context of additional and more effective support to families.

5.90 For those children and young people who need to live away from home the Department launched a major new initiative to assist authorities to perform their parenting role better. The Looking After Children: Good Parenting, Good Outcomes materials enable authorities to monitor in detail the progress of the children they look after across a range of child development aspects including health and education. 1995-96 was the first full implementation year and 39 authorities participated in the scheme. A further 33 authorities are scheduled to join the scheme in 1996-97. The aim is to achieve universal coverage.

Nursery Education

5.91 During 1995-96 the Department of Health worked closely with the Department for Education and Employment in drawing up and consulting on the regime for the administration of nursery education vouchers. In particular, they advised on inspection issues.

Under 8s

5.92 Some steps were taken to deregulate day care services for under-eights and the Department continued to encourage a wider network of support for families. The parenting, family support and out-of-school initiatives all encouraged the refocusing of support to families. These initiatives will be taken forward during 1996-97 through childcare circles which are primarily aimed at encouraging parents to help each other with parenting problems.

Adoption

5.93 Following the Government's White Paper "Adoption: the Future" of November 1993, new legislation is being progressed and will be introduced as soon as the Parliamentary timetable allows. The main objectives of the Bill include improving the adoption service in England and Wales; bringing adoption into line with the Children Act 1989; involving the courts less and at an earlier stage in adoption proceedings; and enabling the UK to ratify the 1993 Hague Convention on intercountry adoption.

5.94 Regulations were laid in 1995 - 96 and guidance issued on the revised structure and functions of adoption panels. These Regulations permit nomination of members from a broader base; amend the current structure of panels; encourage a more independent approach to their work of advising adoption agencies; establish fixed terms of appointment and clarify the roles of certain members.

Children's Employment

5.95 In 1995-96 the Department issued nearly 2,000 copies of a consultation document proposing some changes to the law on the employment of children. The purpose of the changes proposed is to update and clarify the existing law, give children greater flexibility on when they choose to work and to bring domestic legislation in line with the requirements of an European Commission Directive. Work on this will continue in 1996-97.

Juvenile offenders

5.96 The work of the Youth Treatment Service is described in Annex G.

5.97 The Department is engaged with the Home Office in the implementation of the sentencing and remand provisions of the Criminal Justice and Public Order Act 1994. A Ministerial Group on Juvenile Crime has been set up to strengthen measures to identify those children, both above and below the age of criminal responsibility, who are at risk of offending and measures to divert them from becoming involved with crime. The Department is represented on the Group which is expected to reach conclusions in the current year.

5.98 The Department continues to work with local authorities on the Secure Accommodation Programme, which aims to strengthen social services provision for young offenders and those at risk of offending and encourage the increase in local authority secure accommodation necessary to implement juvenile justice policy. A supply plan for the provision of an additional 170 secure places for criminal justice purposes was presented to Parliament in April 1994.

Quality and Registration

Regulation and inspection of personal social services

5.99 The Department has made good progress in taking forward measures aimed at improving the way the Registered Homes Act 1984 is applied and enforced and resolving perceived problems with the current regulatory arrangements. These measures will benefit the regulators, users and providers involved in services for which social services departments have a statutory duty. By focusing on issues such as consistency of standards for care, avoiding unnecessary bureaucracy and encouraging co-operation/consultation, the aim is to ensure positive approaches to use of resources and outcomes.

Guidance on regulation and inspection

5.100 In September 1995, the Department issued guidance on the regulation and inspection of nursing homes and residential care homes to local authorities and health authorities. The guidance promotes a sensible approach to regulation, without any loss of necessary safeguards for vulnerable residents of homes, and encourages authorities to cut bureaucracy to the minimum to ease burdens on home owners. It also encourages all authorities to co-operate with each other, become involved in local business partnerships and keep regulation issues at the top of the agenda.

5.101 The guidance advises on the need for:

- **consistency** in setting standards and enforcement practice;
- **transparency** of regulation and enforcement arrangements to ensure homeowners know what is expected of them;
- **targeting** of enforcement action to ensure it is appropriately directed; and
- **co-ordination** between the different agencies involved in regulation to avoid duplication of effort and unnecessary costs.

Review of regulation and inspection

5.102 On 22 September 1995 the Department launched a major, wide-ranging review of the regulation and inspection of children's and adult personal social services, covering all aspects of regulation and inspection. This exercise follows a commitment made by the Government in 1992 to review progress made towards achieving the essential objectives for social services inspection of effectiveness and independence. The remit for the review has since been extended to cover regulation and inspection across all social services for adults and children. It includes the regulation of nursing homes which provide care (mostly long term or for respite purposes) of a kind which local authorities may be required to arrange under their community care responsibilities.

5.103 The decision to extend the review was taken in recognition of the piecemeal way regulation in social services has developed over the years.

5.104 A consultation document, entitled '**Moving Forward**' has been sent to all local authorities/health authorities, major provider organisations and other parties with an interest. Some of the key issues addressed by the review include:

- consideration of the need for some form of mandatory regulation of those services not covered by the current statutory framework such as day and domiciliary care services for children and adults and private children's homes for less than four children

- statutory distinction between nursing homes (those described in para 5.91) and residential care homes. There have been suggestions that this distinction should be replaced by a single home category under which all homes can provide both residential and nursing care. This is in recognition of the increasing levels of dependency of residents and would put an end to the need for homes currently offering both nursing and residential care to register with both the health and local authority - a requirement which is often seen as bureaucratic and burdensome on homeowners

- organisation of regulation and possible alternative options for the regulatory structure. Any changes will take account of the need for an evenhanded approach to all providers and consideration of the balance between national and local input.

5.105 The consultation process is being taken forward by an independent assessor. Written responses were invited by the end of February. The independent assessor will report to Ministers later in the year.

Training

5.106 A properly trained workforce is essential to the delivery of improving standards of care. The Government remains committed to training for the Personal Social Services and to continuing work with other Government Departments on common elements of the PSS Training Strategy.

5.107 The Training Support Programme specific grant (£35.45 million for 1996 -97) helps support the cost of training staff of Social Services Departments.

Training Strategy for Personal Social Services

5.108 In order to ensure best use is made of all the resources available for PSS training, the Department is reviewing its Training Strategy for Personal Social Services. First launched in 1991, the strategy has enabled the effective targeting of training resources on support for the introduction of the Diploma in Social Work and the development of National Vocational Qualifications and Post Qualifying Awards in social work.

5.109 There is a significant training and development task for the Department and all PSS employers.

National Vocational Qualifications (NVQs)

5.110 NVQs are increasingly becoming available for PSS staff. Action is needed to increase the numbers registered for NVQs and to reduce the time between registration and acquiring the award. Among other things, the Department will therefore:

- focus the TSP on induction and training that enables staff to gain NVQs. (This will also contribute to Government targets for a better qualified workforce); and

- work with key employers and awarding bodies to reduce the time between registration and award.

Diploma in Social Work (Dip SW)

5.111 The Department recognises the need to ensure greater flexibility in the routes to the Diploma and in the numbers of people qualifying. To this end the Department proposes to work with the Central Council for Education and Training in Social Work (CCETSW):

- to continue to develop open and distance routes to Dip SW so as to extend the opportunity to gain the professional qualification, in particular to mature entrants, including staff already working in the independent sector and in residential care; and
- to maintain sufficient Dip SW programmes, in the light of changes to probation training, to ensure the output of adequate numbers of newly qualified professional social workers.

Post Qualifying Education and Training (PQ)

5.112 Training and development are part of a continuous process for Personal Social Services staff. The Department sees PQ as an integral part of its continuum of qualifications for social work. The Department will therefore:

- work with CCETSW to ensure that there is an efficient and effective model for post qualifying education and training that enables staff to develop expert practice within social work.

Joint training

5.113 Recent legislative and policy developments give greater urgency to the need to provide opportunities for joint training. At a local level this must be the employers' responsibility. The Department will assist in this activity by:

- identifying and pursuing opportunities to promote joint training at a central level;
- promoting the involvement of local authorities in the new training consortia of the National Health Service to further encourage joint training; and
- ensuring that the importance of joint training is reflected in training and materials commissioned or produced by the Department.

The Training Support Programme (TSP)

5.114 The achievement of many of these initiatives will be assisted by a re-focusing of the TSP. The Department has therefore decided to:-

- increase the focus of the TSP by introducing targets for the achievement of induction training and competence-based qualifications (especially NVQ and PQ); and
- simplify and reduce the administrative requirements of the TSP.

5.115 Authorities will be asked to make further progress in workforce planning, including identification of the current qualifications status of their employees and setting targets for improvement. In the light of this and other external targets, and in consultation with employer and professional interests, Government will work towards setting targets for the PSS workforce.

Training for the independent sector

5.116 Existing Government policy is that training is the responsibility of employers in all sectors. The Department will discuss with purchasers and the independent sector how proper provision for training costs can be taken into account in commissioning and contracting.

6 MANAGING THE DEPARTMENT OF HEALTH

Introduction

6.1 Responsibility for managing the Department rests with the Departmental Resources and Services (DRS) Group. Provision for the objectives in this chapter appears in the 1996-97 Main Estimate for Class XI, Vote 2. The Secretary of State has agreed the following medium term objectives for this Group:

- support business groups in managing their resources effectively and efficiently, in a way best suited to the new Departmental structures, and ensuring that Government requirements on financial and human resource management are met;
- set a context for staff to give of their best by developing and putting into practice a new approach to human resource management, including better systems of appraisal, skills assessment and development; and
- Further the Department's policy objectives by ensuring the provision of high quality statistical, economic, operational research, financial and public relations support as efficiently as possible and responsive to requirements of the relevant business groups.

Management and Resources

6.2 **Table 29** gives information about the running costs of the Department of Health. **Table 31** gives information about staffing levels.

Table 29- Departmental Running Costs

£ million

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn outturn	1995-96 estimated	1996-97 plans	1997-98 plans	1998-99 plans
Department of Health									
Gross running costs[1]									
Paybill	136	149	164	155	151	150			
Other	129	143	167	155	144	152			
Total	265	293	331	310	300	302	287	278	278
Related receipts	-13	-21	-16	-13	-10	-14	-16	-13	-13
Net expenditure	252	272	315	298	290	289	271	265	266
Running costs by control area:									
Gross control	248	274	311	301	293	294	276	269	270
Net control areas:									
Medicines Control Agency[2]									
Gross expenditure	9	12	13						
Net expenditure	5		7						
NHS Estates Agency									
Gross expenditure	8	7	7	9	7	8	11	9	9
Net expenditure	1	-1	-1	1					

(1) The gross figures are net of any VAT refunds on contracted out services.
(2) The Medicines Control Agency became a Trading Fund on 1 April 1993 and previously operated under net running costs control.

Table 30 - Department of Health and Agencies - Staff Numbers

Staff years

1 April - 31 March		1990-91 actual[1]	1991-92 actual[1]	1992-93 actual[1]	1993-94 actual[1]	1994-95 actual[1]	1995-96 estimate	1996-97 plans[2]	1997-98 plans[2]	1998-99 plans[2]
Department of Health[3]	Civil Servants	5,150	4,355	4,413	4,412	4,325	3,703	4,585	4,585	4,585
	Overtime	82	96	92	49	42	43	40	40	40
	Casuals	167	136	211	177	240	235	220	200	180
	Total	5,399	4,587	4,716	4,638	4,615	3,981	4,845	4,825	4,805
NHS Estates Agency[4]	All Staff	(1)	130	138	106	106	103	180	180	180
Medicines Control Agency[5]	All Staff	(2)	266	322	349	250	363	440	430	420
Total Departmental of Health and Agencies		5,399	4,983	5,176	5,093	4,971	4,447	5,465	5,435	5,405

(1) Source for 1990-91 to 1994-95 actual staff numbers: average of monthly Staff in Post figures.
(2) Planned numbers are rounded to nearest 10.
(3) Assumed that the Department (gross control area) will achieve a manpower reduction of 15% by April 1996 and 21% by March 1997. Also assumes 1100 Regional Office staff joining the NHS Executive in DH from 1 April 1996.
(4) The NHS Estates Agency became subject to net running costs control from April 1995. Figures for 1990-91 are included within the Department of Health (Gross Control Area).
(5) The Medicines Control Agency became a trading fund on 1 April 1993. Figures for 1990-91 are included within Department of Health (Gross Control Area).

6.3 The Department of Health is involved in a period of major change, in the wake of the changes in the management of the NHS and increased focus on devolved responsibilities. It has undergone two fundamental reviews of the roles, responsibilities and staffing of (different parts of) its structure in recent years - the Functions and Manpower Review of the NHS and the NHS Executive and the Banks Review of the wider Department. It has also embarked on a programme to make substantial efficiency gains in its running costs, reducing its staff numbers and related costs by 21 per cent by 31 March 1997 and other costs by 20per cent, as compared to the position at 1 April 1994.

6.4 For the purposes of comparison, the running costs and staff of the NHS Executive Regional Offices who will join the Department on 1 April 1996 are excluded from this calculation. Each of the Department's Executive Agencies has its own programme to reduce its costs and staff numbers. In the Budget on 28 November 1995 it was announced that a further saving of 5 per cent would be made in 1996-97 on the running costs of the Department, including the Regional Offices and the Agencies under gross running costs control.

6.5 A **voluntary early retirement/severance** scheme was launched in October 1994. Its primary aim was to help to reduce the size of the Department and avoid the need for compulsory redundancies. There was a large response to the scheme and it was agreed that 1057 staff would be allowed to leave, enabling the Department to meet the necessary reductions by voluntary means.

Baseline Performance

Serving Parliament and the Public

6.6 The Department of Health has one of the heaviest post bags in Whitehall. 145,237 pieces of correspondence were received in 1995. Ministers replied to 18,117 letters and the rest were dealt with by officials. In addition 5,445 Parliamentary Questions were answered.

6.7 In January 1995 the Public Appointments Unit (PAU) at Cabinet Office published a ***Review of Guidance on Public Appointments***. The report's main recommendations cover the advertising of vacancies, the interviewing of short-listed candidates, the recording of reasons for Ministers' decisions and the public announcement of the outcome. It also recommended that job descriptions, performance monitoring, codes of conduct, and induction and training should all be mandatory for appointees. The recommendations have been endorsed by Ministers and are being implemented by the Department.

6.8 In February, the then Secretary of State published the Department's own *Guidance on procedures for appointments to NHS authorities and trusts* which incorporates many of the recommendations of the PAU review. The key principles of the guidance are that:

- it is open to anyone to become an NHS non-executive providing they are committed to the values of the NHS and that they are able to bring to the post skills, knowledge and experience which will help the organisation do its job better; and

- procedures are transparent and clear to potential candidates.

6.9 The Guidance was implemented by the NHS Executive in April and has been followed for all appointments to NHS authorities and trusts since - including the major trust re-appointments exercise involving some 600 appointments - and is being used for appointments to the new Health Authorities.

6.10 The Department's Guidance for appointments to NHS authorities and trusts was presented as evidence to the Committee on Standards in Public Life (the Nolan Committee). In its first report, published in May 1995, the Committee welcomed this initiative and made a number of additional recommendations .

6.11 These recommendations, which were accepted by the Government, covered issues such as the standards of conduct expected of public bodies and those appointed to them, the introduction of an independent member on sifting panels, the declaration of significant political activity by candidates and the introduction of improved procedures for appointments to all NHS bodies and executive NDPBs. In many cases the Department's existing arrangements were already in line with the report's recommendations and work is under way to implement the remainder.

6.12 The first full list of appointments to NHS bodies and the Department's executive NDPBs will be published in the summer of 1996.

6.13 The **Code of Practice on Access to Government Information**, which first came into operation in April 1994, has continued to influence the Department of Health's handling of official information. This has been achieved by:

- consolidating the practice of explaining the reasons underlying its policies and publishing the key facts relating to policy announcements;
- publishing information in accordance with Citizen's Charter principles, such as the second set of NHS Performance tables for England which were published in June 1995 covering NHS performance against various Patient's Charter standards; and
- making information available, in response to specific requests, relevant to the Department's policies, actions and decisions.

Payment of Bills

6.14 The Department's policy is to pay suppliers within the time limits agreed and specified in contracts with them. This will normally be within 30 days. Where appropriate, departmental contracts also require contractors to make payments to sub-contractors within 30 days of receipt of an invoice. The percentage of invoices paid within the contracted period or, where no terms were set within 30 days of the presentation of a valid invoice was 87.1 per cent in 1993-94, 91.9 per cent in 1994-95 and 95.2 per cent in 1995-96. See also paragraph 4.70.

Maladministration

6.15 Two payments for maladministration were made in 1995, totalling £80,535. One of the instances of maladministration occurred in 1985, the other in 1994.

Deregulation

6.16 The Department is fully committed to the deregulation initiative and attaches great importance to reducing regulatory, administrative and enforcement burdens on business, the voluntary sector and local government. The Department of Health's strategy for reducing such burdens, its achievements in 1995-96 and plans for 1996-97 are set out at **Annex I**.

Departmental Spending on Publicity and Advertising

6.17 The Department runs a number of publicity campaigns directly and funds others run by the HEA. Spending in 1995- 96 is planned to be £52 million. The main components of this are given in **Table 31**. The balance of £14.5 million includes other Health Education Authority campaigns (including their cancer campaign) and Departmental core expenditure, which includes over 50 separate campaigns, many of which amount to only a few thousand pounds each.

Table 31 - Departmental spending on publicity and advertising 1995-96

	£ million
Campaigns run by the Department	
Health of the Nation	2.6
Organ Donation	1.5
National Blood Service Publicity	1.3
Help with NHS Treatment Costs	1.2
Health Service Professional Recruitment	1.0
Drug and Solvent Misuse	0.9
GP Out of Hours Patient Education	0.9
Overseas Travel	0.8
Keep Warm Keep Well	0.6
Patients Charter	0.5
Unification of Prescription Charges	0.5
Community Care	0.5
Total	12.3
Campaigns run by the Health Education Authority	
Anti-Smoking Campaigns	6.7
HIV & AIDS	4.2
Drugs	4.3
Look After your Heart (including Physical Activity)	3.3
Vaccination and Immunisation	2.3
Parenting & Child Health	1.3
Folic Acid	1.1
Alcohol	1.1
Contraceptive Education	0.9
Total	25.2

Value for Money

6.18 To deliver the savings referred to at paragraph 6.4, while still maintaining essential functions and quality of work, the Department has continued to seek value for money in the services it needs to support its main business. Competing for Quality measures have played an important role in this. Up to 31 March 1995, the Department achieved savings of £11.2 million through Competing for Quality, representing 28 per cent of the value of the programme.

6.19 Following the White Paper "Continuity and Change", the Department published an Efficiency Plan for the first time in 1995, bringing together in one document the measures being taken to manage the Department's business more efficiently and effectively. Competing for Quality measures were incorporated into the 1995 Efficiency Plan. Efficiency Plans provide a structured mechanism for Departments and Executive Agencies to:

- integrate the full range of efficiency measures under one approach, thereby producing a better focus to Departments' efforts in delivering key outputs in the most efficient way;
- demonstrate how they propose to live within running cost limits for the next three financial years; and
- illustrate how they are implementing the Government's policies on promoting competition and encouraging greater private sector involvement.

6.20 The 1995 Efficiency Plan focused upon achieving the optimal structures proposed by the reviews referred to above. Various efficiency techniques have been used including market testing in 1995-96 of services with a value of £6.1 million. The Department has since added market tests of functions with a total value of the order of £10 million, (bringing the total value of services being tested this year to £16 million) and all these tests are well underway. Other measures to promote more efficient working are also underway, such as the development of Service Level Agreements with some of the Department's Agencies and other Government Departments which provide services to DH.

Executive Agencies

6.21 The Department has set up four **executive agencies** under the **Next Steps** programme:

- the Medical Devices Agency. This Agency was launched on 27 September 1994.
- the Medicines Control Agency. A Prior Options study of the Medicines Control Agency was carried out in 1994, and Ministers have agreed its conclusions that the options of abolition, privatisation and the contracting out of the Agency's core functions are not practicable or feasible. However, there are support functions which might beneficially be placed on a contractual basis.
- the NHS Pensions Agency. Ministers are still considering the recommendations from the prior options review of the NHS Pensions Agency.
- the NHS Estates Agency. Following the completion of the review of the NHS Estates Agency, Ministers have announced their intention to privatise in due course the Agency's non-core functions.

6.22 The relationship between the Department and the Agencies is set out in the relevant Framework Documents. Further details about the management of the Agencies are set out at **Annex G**.

Equal opportunities

6.23 Following a policy review in 1994, the Department's 1995-96 Equal Opportunities Action Plan contains a number of initiatives aimed at embedding equal opportunities more firmly into the culture and business of the Department. The Department has:

- embarked on a programme of equal opportunities awareness seminars for senior managers;
- set up new monitoring arrangements for personnel procedures; and
- prepared a new complaints procedure which will be issued to all staff in early 1996.

6.24 In February 1996 the Department:

- submitted a proposal to the Employment Service in order to gain the Disability Symbol; and
- began a pilot audit of equal opportunities in one of the Department's business areas.

Recruitment

6.25 With the exception of three extensions of short term appointments beyond the initially publicised period and a conversion to permanency due to the professional skills of the individual there was no recruitment into the Department from 1 April 1994 to 31 March 1995. 94 staff joined the Department on secondment during this period.

6.26 Systems have been put in place which enable the Department to monitor all recruitment exercises in line with the requirements of the Civil Service Order in Council 1995 and the Commissioners' Recruitment Code.

London Accommodation Strategy

6.27 In July 1995 the Department completed its London Accommodation Strategy with all staff housed in new or refurbished accommodation in a small number of core buildings south of the river together with Richmond House in Whitehall. The major buildings now occupied by the Department and its Agencies are shown in **Table 33**. The Department also occupies accommodation in a further 21 buildings, mainly outside London, totalling 16,000 m^2, which are either leased or where another Government Department is the major occupier with responsibility for the building.

Table 32 - Main buildings occupied by Department of Health and its Agencies 1995-96

Building	Departmental Occupier	Tenure	Building Area (m^2)
Richmond House	London HQ and DSS	Freehold	11,800
Skipton House	London HQ	Leased	19,300
Wellington House	London HQ	Freehold	11,400
Eileen House	London HQ	Leased	6,830
Hannibal House	London HQ and Medical Devices Agency	Leased	8,300
Market Towers	Medicines Control Agency	Leased	9,000
Glenthorne Centre	Youth Treatment Service	Freehold	7,000
St Charles Centre	Youth Treatment Service	Freehold	4,600
Quarry House	NHS Executive	Minor occupier of Benefits Agency	22,000
Trevellyan Square	NHS Estates	Leased	2,100
Hesketh House	NHS Pensions Agency	Leased	9,400

Environmental Stewardship

6.28 The Department continues to be committed to sound environmental stewardship in the management and "housekeeping" of its estate and daily business. The Department's first Environment and Energy Action Plan was successfully completed. It included energy-saving audits, a review of recycling facilities and promoting staff awareness. In the coming months the Department will prepare a second Action Plan to build on this work.

Improvement Plans

6.29 The Department is taking a number of steps to ensure that staff can meet key objectives and maintain and improve the essential services to Ministers and the general public. Much of this work implements the recommendations of the **Efficiency Unit Scrutiny on Resource Management Systems**, published in May 1995. The Action Plan for implementing these recommendations drew together the initiatives already under-way to improve the overall management of the Department and set out a range of improvements that are now being implemented, including:

- the issue of a set of aims and medium term objectives agreed by the Secretary of State at the start of the business planning round in December 1995, which set a framework for planning for 1996-97 and beyond (these medium term objectives are presented in this report at the beginning of each chapter);

- a new business planning timetable which seeks to reinforce and improve the links between the various planning cycles, in particular programme planning;

- a business planning process that aims to show more clearly the links between resources, work programmes, and outputs;

- monitoring of objectives against targets and expenditure against budgets, as set out in business plans throughout the year;

- developing the business planning and resource management systems to provide better information information to Ministers and all managers in the Department to support the planning and prioritisation of work programmes and the effective allocation and management of resources;

- building in the use of various management techniques to promote the more efficient use of resources (in accordance with the White Paper "Continuity and Change") is an integral part of the business planning process;

- re-engineering core business processes, such as answering Ministerial correspondence and Parliamentary Questions, to reduce the amount of resources needed to carry out these activities;

- identifying and meeting staff training and development needs within the context of pursuing Investors in People accreditation, to ensure staff do their jobs effectively and meet key business objectives;

- introducing resource accounting from 1997-98. This follows the publication of the White Paper - Better Accounting for Taxpayer's Money. The first year for which resource accounts for the Department are published and laid before Parliament will be 1999 - 2000;

- reviewing the Department's accommodation needs;

- reviewing the Department's internal communications;

- reforming pay and grading structures, both for staff below grade 5 level and for grade 5 and above (where the Department will need to make best use of the creation of the Senior Civil Service). These changes will remove the inflexibilities of a rigid grading structure and give managers greater discretion in the way they reward and motivate their staff; and

- in the light of the changes above, introducing a system for job specific selection to posts and reviewing the Department's performance appraisal system.

6.30 To ensure that the changes achieve their optimal impact it is important that they are clearly well-coordinated, and that staff feel that they themselves have an opportunity to use the changes to make a positive difference to the way in which they do their work. The Department has therefore embarked upon an organisational development programme - **Shaping the Future** - which aims to integrate the various initiatives into a coherent programme of change, involving all staff in the process of building the new organisation. The formal programme lasts until June 1996.

6.31 To support this programme the Department is carrying out a review of its Human Resource functions and a specific exercise to co-ordinate and map the various central change initiatives affecting the Department.

ANNEXES

Annex A

Cash Plans

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In 1996-97 the figure for NHS hospital, community health, family health services (cash limited) and related services current expenditure should read 26,211 instead of 26,216 and total expenditure should read 26,208 instead of 26,213; the figure for NHS family health services (non-cash limited) General Medical Services should read 2,056 instead of 2,047 and total expenditure should read 5,570 instead of 5,561; the figure for Departmental administration Central department should read 251 instead of 255 and total expenditure should read 276 instead of 280.

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 estimated outturn	1996-97 plans	1997-98 plans	1998-99 plans
Department of Health									
Central government expenditure									
Health services									
Voted in Estimates									
National Health Service hospital, community health, family health (cash limited) and related services									
Current expenditure	15,642	18,206	20,259	21,691	23,308	24,857	26,216	24,874	25,438
Capital expenditure	1,400	1,239	1,091	550	275	256	-2	-6	-12
Total	17,092	19,498	21,405	22,298	23,640	25,112	26,213	24,868	25,426
National Health Service trusts		39	225	333	577	505	476	446	405
National Health Service family health services (non-cash limited)									
General Medical Services	1,484	1,657	1,766	1,839	1,901	1,966	2,047		
Drugs	2,089	2,192	2,346	2,323	2,221	2,222	1,846		
Dispensing costs	559	604	658	677	679	716	744		
Prescription charge income	-206	-218	-242	-265	-287	-295	-310		
General dental services	660	842	911	855	896	918	989		
General ophthalmic services	111	141	172	192	213	223	243		
Other family health services	1		2	2	2	3	2	7,805	8,101
Total	4,699	5,219	5,613	5,622	5,625	5,754	5,561	7,805	8,101
Departmental administration									
Central department	232	258	324	273	267	265	255	243	244
NHS Estates Agency		-2	-1		-1	-1	-1	-1	-1
NHS Pensions Agency	18	19	10	21	20	19	17	15	15
Medical Devices Agency	10	10	10	11	11	10	10	11	10
Youth Treatment Service	3	3	4	4	6	3	-1	-1	-1
MCA	4	-5							
Total	266	283	346	309	302	297	280	267	267
MCA Trading Fund				5					
Central health and miscellaneous services									
Non departmental public bodies and special health authorities	56	73	75	78	80	78	80	80	82
Other services including medical scientific and technical services, grants to voluntary bodies, research and development and information services	130	187	155	154	156	159	154	164	165
Welfare food and European Economy area medical costs	131	158	193	214	222	273	292	295	305
Total	317	417	423	446	458	510	526	539	551
Total voted in Estimates	**22,324**	**25,404**	**27,957**	**28,956**	**30,544**	**32,179**	**33,056**	**33,925**	**34,751**
Of which:									
Central government's own expenditure	*22,324*	*25,365*	*27,733*	*28,619*	*29,968*	*31,675*	*32,581*	*33,480*	*34,347*
Public corporations		*39*	*225*	*333*	*577*	*505*	*476*	*446*	*405*
Trading funds				*5*					
Other (non-voted)									
National Health Service hospital, community health, family health (cash limited) and related services									
Current expenditure									
Capital expenditure	-3								
Total	-3								

National Health Service trusts		-64	-2	-30	14	-23	-36	-53	-89
National Health Service family health services (non-cash limited)									
General Medical Services									
Drugs									
Dispensing costs									
Prescription charge income									
General dental services									
General ophthalmic services									
Other family health services	-10								
Total	-10								
Departmental administration									
Central department	15	16	16	17	16	17	17	17	17
NHS Estates									
NHS Pensions Agency									
Medical Devices Agency									
Youth Treatment Service									
MCA		-2							
Total	15	14	16	17	16	17	17	17	17
MCA Trading Fund									
Current expenditure				9	9	10	10	10	10
Central health and miscellaneous services									
Non departmental public bodies and special health authorities									
Other services including medical scientific and technical services, grants to voluntary bodies, research and development and information services			-1	-1	-2				
Welfare food and European Economy area medical costs									
Total	-1		-1	-1	-2				
Total other (non-voted)	**2**	**-50**	**13**	**-6**	**37**	**5**	**-9**	**-25**	**-61**
Of which:									
Central government's own expenditure	*2*	*14*	*16*	*24*	*23*	*27*	*27*	*27*	*27*
Public corporations (excluding nationalised industries)		*-64*	*-2*	*-30*	*14*	*-22*	*-36*	*-52*	*-88*
Total Health Services	**22,326**	**25,354**	**27,971**	**28,951**	**30,581**	**32,183**	**33,047**	**33,900**	**34,690**
Of which:									
Central government's own expenditure	*22,327*	*25,379*	*27,749*	*28,644*	*29,991*	*31,702*	*32,608*	*33,506*	*34,373*
Public corporations (excluding nationalised industries)		*-24*	*223*	*303*	*590*	*482*	*440*	*393*	*316*
Trading funds				*5*		*1*	*1*	*1*	*1*
Other Services									
Voted in Estimates									
Personal social services									
Current expenditure	19	26	30	32	32	34	34	34	33
Capital expenditure	-1	-1	2	3		-2	-1	-1	-1
Total	18	25	31	34	32	32	33	33	32
Civil Defence	1	1	1	2	1	1	3	3	3
Total voted in Estimates	**19**	**26**	**32**	**36**	**33**	**33**	**35**	**36**	**35**
Of which:									
Central government's own expenditure	*19*	*26*	*32*	*35*	*32*	*32*	*35*	*35*	*34*
Total other (non-voted)									
Of which:									
Central government's own expenditure									
Public corporations (excluding nationalised industries)									
Total central government expenditure	**22,345**	**25,380**	**28,003**	**28,987**	**30,613**	**32,216**	**33,083**	**33,935**	**34,725**
Of which:									
Central government's own expenditure	*22,345*	*25,405*	*27,781*	*28,679*	*30,023*	*31,734*	*32,643*	*33,541*	*34,408*
Public corporations (excluding nationalised industries)		*-24*	*223*	*303*	*590*	*482*	*440*	*393*	*316*
Trading funds				*5*		*1*	*1*	*1*	*1*

Central government grants to local authorities									
Voted in Estimates									
Current grants within AEF									
Training support programme for social services staff	19	25	29	32	33	35	35	35	35
Services for people with HIV and AIDS	10	10	15	12	13	13	14	14	14
Services for alcohol and drug misusers		1	2	2	2	2	2	2	2
Services for people with mental illness		19	30	34	36	47	58	67	67
Guardian ad litem and reporting officer service		6	6	6	6	6	6	6	
Community care grant				565	736	648	418		
Provision of secure accommodation									
Unaccompanied asylum-seeking and refugee children							3	3	5
Long-term care capital disregard increase							64	33	33
Capital grants									
Provision of secure accommodation	2	2	1	2	5	21	27	13	8
Rehousing of displaced families									
Total central government grants to local authorities	**31**	**58**	**83**	**654**	**831**	**772**	**628**	**175**	**170**
Of which:									
Current within AEF	*29*	*56*	*82*	*652*	*827*	*752*	*537*	*128*	*128*
Capital	*2*	*2*	*1*	*2*	*5*	*21*	*92*	*47*	*42*
Credit approvals	**84**	**106**	**126**	**132**	**140**	**145**	**103**	**103**	**103**
Total central government support to local authorities	**115**	**164**	**209**	**786**	**972**	**918**	**732**	**278**	**273**
Total Department of Health	**22,461**	**25,544**	**28,213**	**29,773**	**31,585**	**33,134**	**33,815**	**34,213**	**34,998**
Of which:									
Voted in Estimates	*22,374*	*25,488*	*28,073*	*29,646*	*31,408*	*32,984*	*33,721*	*34,135*	*34,956*

Reconciliation between Cash Plans Table and Estimates

£ million

	1994-95 outturn	1995-96 estimated outturn	1996-97 plans
VOTED EXPENDITURE INCLUDED IN THE CONTROL TOTAL	31,408	32,984	33,721
VOTED EXPENDITURE NOT INCLUDED IN THE CONTROL TOTAL			
Department of Health			
Trust debt remuneration	890	930	1000
NHS contributions	-4,019	-4,297	-4,467
Pensions	682	833	922
Other	1	1	1
TOTAL VOTED EXPENDITURE NOT INCLUDED IN THE CONTROL TOTAL	-2,446	-2,584	-2,544
EC RECEIPTS			
Research and Development			
TOTAL EC RECEIPTS			
TOTAL VOTED EXPENDITURE	28,962	30,450	31,176

Annex B

National Health Services, United Kingdom - Gross Expenditure

	1990-91 outturn	1991-92 outturn	1992-93 outturn	1993-94 outturn	1994-95 outturn	1995-96 estimated outturn	1996-97 plans	1997-98 plans	1998-99 plans
Central government expenditure									
National Health Service hospital, community health, family health (cash limited) and related services	21,770	24,614	26,753	27,686	28,772	29,950	31,061	31,842	32,496
National Health Service trusts		-25	222	313	613	732	495	407	314
National Health Service family health services (non-cash limited)	6,467	7,322	8,003	8,389	8,873	9,312	9,742	10,134	10,509
Departmental administration	318	349	413	372	365	364	349	335	334
MCA Trading Fund				5	0	1	1	1	1
Central health and miscellaneous services	623	784	847	725	745	807	837	859	869
Total National Health Service	**29,178**	**33,044**	**36,238**	**37,940**	**39,368**	**41,166**	**42,485**	**43,578**	**44,523**
Total at 1994-95 prices (using GDP deflator)	**33,825**	**36,055**	**37,995**	**38,194**	**39,369**	**40,064**	**40,240**	**40,269**	**40,238**
Percentage change		**+6.6**	**+5.4**	**+0.5**	**+3.1**	**+1.8**	**+0.4**	**+0.1**	**-0.1**

Annex C

Ministerial Responsibilities

Secretary of State: The Rt Hon Stephen Dorrell MP

Overall responsibility for: The work of the Department and (until April 1996) that of the Office of Population, Censuses and Surveys.

Minister of State (Minister for Health): Gerald Malone MP

Responsibility for: NHS general and management issues; Purchasing; Primary care and GP Fundholding;General Medical Services; NHS pay; Research; NHS personnel; Medical and dental manpower and education; Junior doctors' hours; NHS communications; Sponsorship including health exports; Pharmaceutical industry including PPRS; Pharmaceutical industry including prescribing and NHS drugs bill; Medicines (licensing issues etc.); Independent health care sector; London issues; General Dental Services; General ophthalmic services; NHS appointments: overview; North Thames, South Thames, Trent, West Midlands; European Union and international affairs;

Parliamentary Under Secretary of State: John Horam MP

Responsibility for: Acute services (including cancer); Blood; Laboratories; Supplies; Private finance initiative; Income generation; VFM/competitive tendering; Capital investments; DH management (including Agencies); Deregulation; OPCS (until April 1996); Patients Charter; Waiting Lists; Complaints; Community Health Councils; NHS casework: closures, mergers, AIPs, Trusts; a. Northern & Yorkshire, Trent, W. Midlands, N. Thames; b. North West, S. Thames, South & West; c. Anglia & Oxford; NHS Appointments - a. Northern & Yorkshire Regions; b. North West; Transplantation; Ambulances and A&E; Civil defence; Information & information systems; Statistics; Information technology; Confidentiality; Abortion; Family planning; Human Fertilisation & Embryology Authority (HFEA); Hospital security; NHS estates; Crown immunity.

Parliamentary Under Secretary of State: John Bowis OBE MP

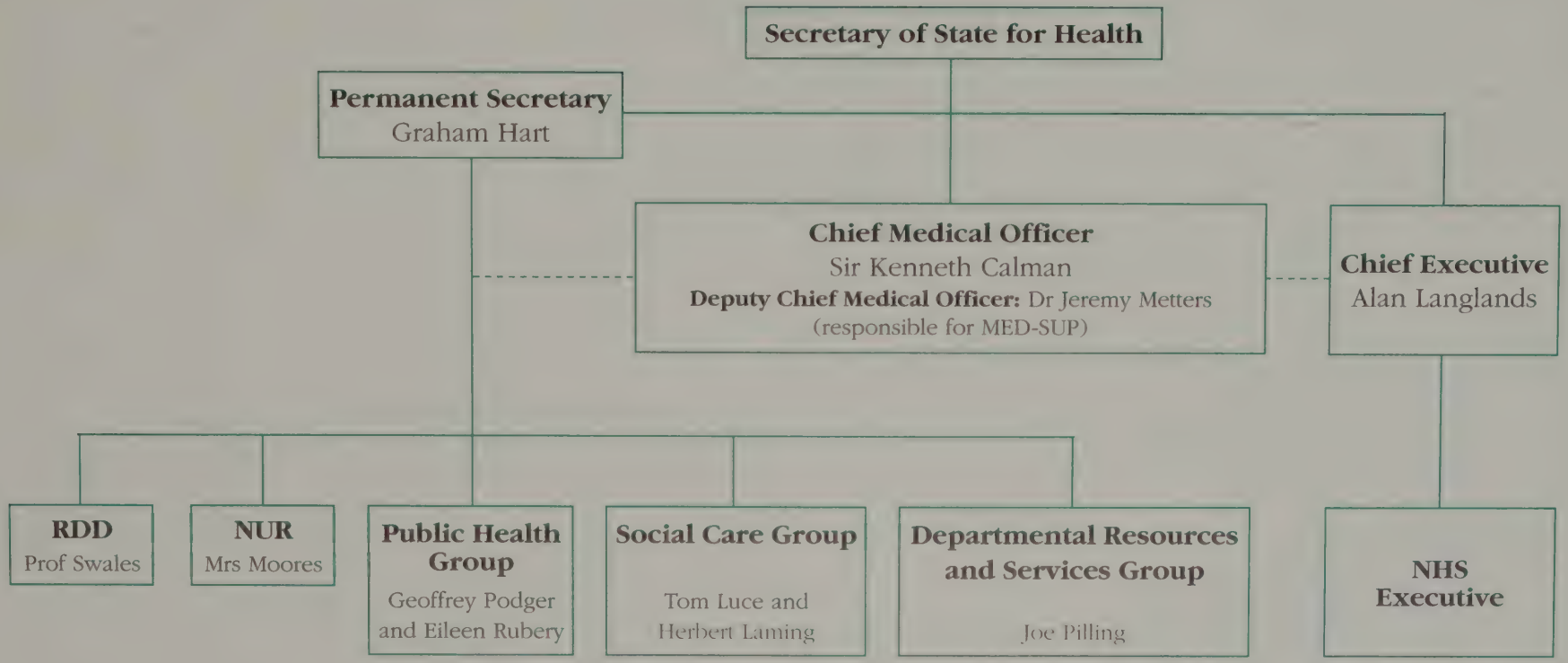
Responsibility for: Community care; Personal social services; Special hospitals; Homeless people; Alcohol; Drugs; Services for elderly people; Services for people with mental illness; Disabilities, including people with sensory and learning disabilities; Children's services (inc. adoption, fostering, child protection, DH aspects of juvenile offenders; NHS Appointments Anglia & Oxford, South & West Regions; Voluntary sector (including S64 grants); Sponsor Minister for Nottingham, Leicester and Derby.

Parliamentary Under Secretary of State: Baroness Cumberlege CBE

Responsibility for: AIDS/HIV; Cot deaths; Ethnic health; Euthanasia; Family issues; Health education and promotion; Health variations; Immunisation; Infectious diseases; Public health; Smoking; Women's health, including maternity services, breast and cervical cancer screening and treatment; All Parliamentary Business in the Lords; Alternative therapies; Environment and health, including pesticides, sheepdips and air quality; Food safety; Green issues; Health of the Nation; Health Education Authority; Hospices; Hospital Chaplaincy; Nursing; Nutrition; Opportunity 2000; Professions allied to medicine (PAMS) including physiotherapists, speech therapists, occupational therapists and chiropodists.

Annex D

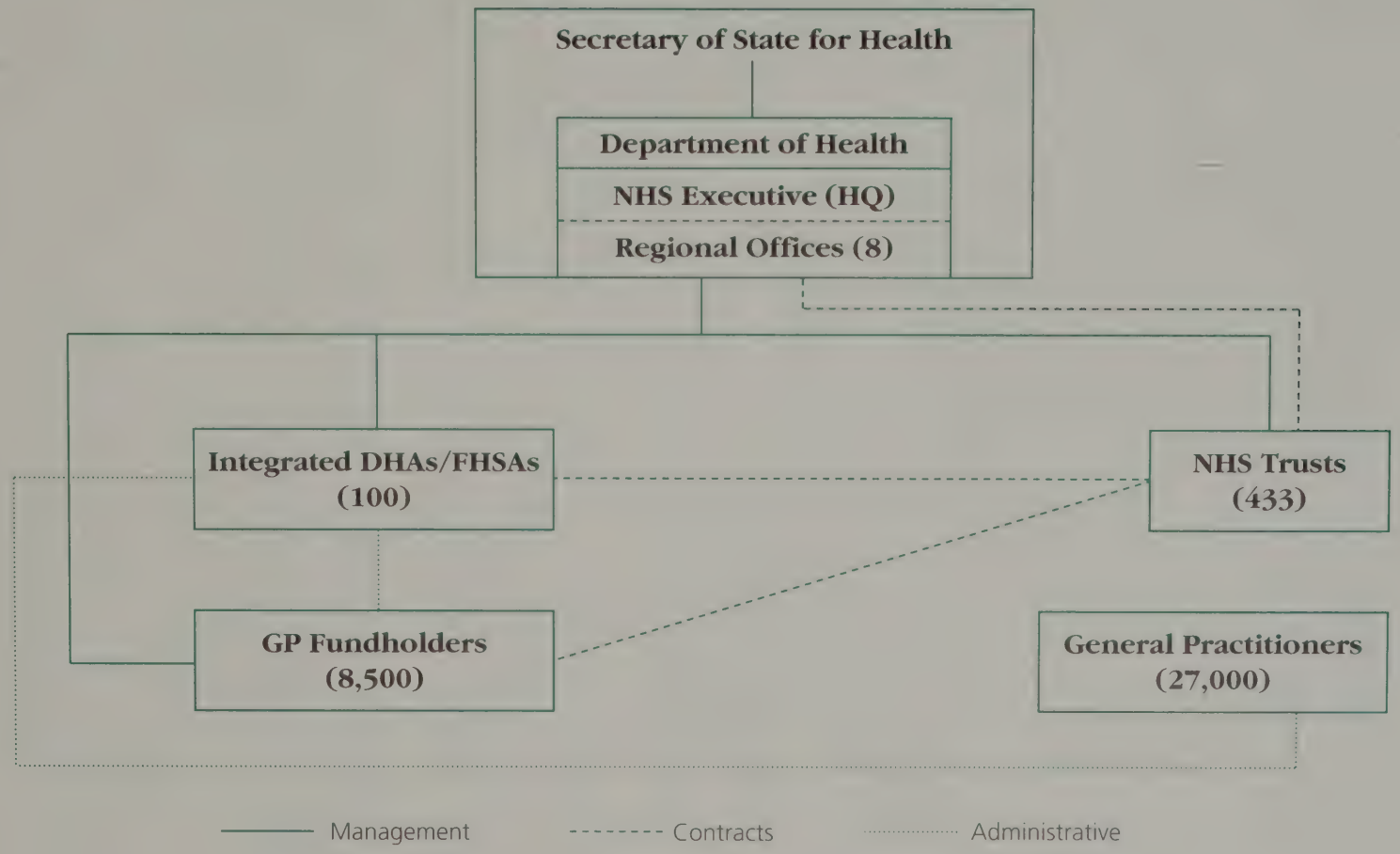
Structure of Department of Health



1. The Chief Medical Officer provides medical advice to the whole Department.
2. Departmental Agencies are not shown.
3. RDD and NUR also report through the NHS Executive.

Annex E

Structure of the National Health Service



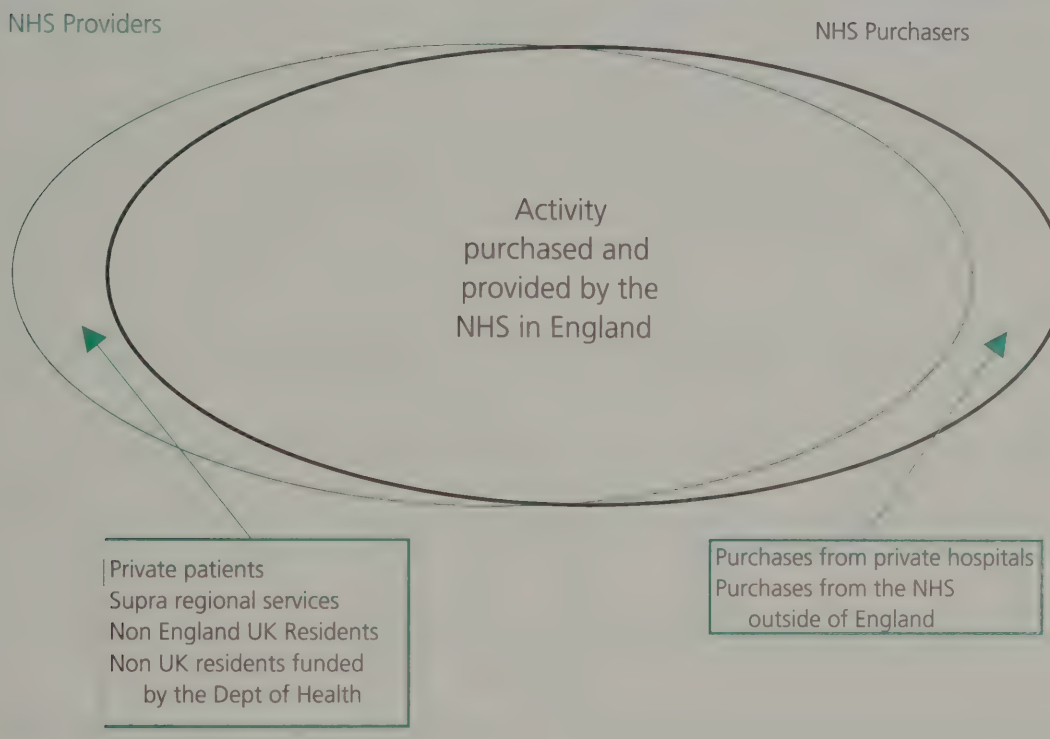
Annex F

Purchaser and provider based data

Introduction

There are inherent differences between activity reported by NHS purchasers and NHS providers in England. **Figure F1** shows schematically the relationship between the two sets of data.

Figure F1 Coverage of NHS provider and NHS purchaser activity data in England.



Differences in coverage

The levels of activity recorded by NHS providers (trusts and DMUs) include privately funded patients and patients from outside England, but exclude NHS funded care provided by non NHS providers.

In comparison, purchaser activity measures purchases made by English Health Authorities and GP fundholders for their populations whether carried out by NHS or non NHS providers in England or elsewhere in the U.K. This includes activity purchased from private hospitals and NHS hospitals outside England but excludes private patients and patients from outside England treated in English NHS hospitals. Therefore, the common ground between purchasers and providers is activity which has been both purchased and provided by the NHS in England.

Table F1 summarises trends in activity purchased by health authorities and GP fundholders. The main points are:

- Weighted activity growth in 1994-95 was some 5 per cent, about the same as in each of the preceeding two years. The current estimate for 1995-96, using activity levels recorded in the first half of the year, is also around 5 per cent.

- The overall growth of general and acute (G&A) inpatient activity in 1994-95 was 6.6 per cent, compared with an average annual growth (based on the last three years) of 5.7 per cent. Performance in the first half of the year suggests a growth of around 6 per cent for 1995-96.

- Growth in total elective activity increased to 8.6 per cent in 1994-95, due to growth of 20 per cent in day cases. Day cases accounted for more than 52 per cent of total elective activity in 1994-95.

- Non-elective admissions have increased steadily over recent years. The growth of 4.2 per cent for 1994-95 was slightly below the average annual growth of 4.4 per cent. The estimate for 1995-96 is over 5 per cent. Work is in hand better to understand the factors underlying the sharp increases in emergency admissions experienced by some providers.

- Reflecting the drive to reduce outpatient waiting times, outpatient first attendance grew by over 6 per cent in 1994-95, and the current estimate for 1995-96 is around the same level.

- In contrast to previous years, in 1994-95 the number of community bed days (in nursing homes, residential homes and group homes) for the mentally ill grew by more than the reduction in hospital bed days, an increase of 400,000 compared with a decrease of 230,000 respectively.

- There was an increase of 1.9 per cent in total community and paramedical contacts in 1994-95 compared with the number purchased in 1993-94.

Table F1 Hospital and Community Health Services: Purchaser Based Activity for the years 1991-92 to 1995-96

'000s and percentages

	Outturn 1991-92	Outturn 1992-93	Outturn 1993-94	Outturn 1994-95	Average annual growth 1991-92 to 1994-95	1994-95 growth over 1993-94	Estimated Growth from first half of 1995-96
Weighted activity Growth	n/a	5.0%	4.8%	5.2%	5.0%	5.2%	4.9%
General & Acute Total (finished consultant episodes)	7,280	7,650	8,080	8,610	5.7%	6.6%	6.1%
Total electives	3,820	4,070	4,290	4,660	6.9%	8.6%	6.5%
Elective ord admissions	2,380	2,350	2,270	2,230	-2.1%	-1.8%	-4.0%
Day Cases	1,440	1,720	2,020	2,430	19.1%	20.3%	17.0%
Non-elective admissions	3,460	3,580	3,780	3,940	4.4%	4.2%	5.7%
General & Acute First Outpatient attendances	8,470	8,700	8,960	9,520	3.9%	6.3%	5.8%
Accident & Emergency Attendances	n/a	12,730	13,190	13,470	1.9%	2.1%	3.1%
Ambulance Journeys Emergency and Urgent	n/a	3,130	3,300	3,470	3.5%	5.3%	2.5%
Mental Illness Hospital bed days	14,450	13,820	12,550	12,320	-5.2%	-1.8%	-1.8%
Community bed days	1,860	2,350	2,740	3,140	19.1%	14.6%	14.8%
Day Care Attendances	3,850	3,950	4,070	4,300	3.8%	5.7%	-3.5%
Community Contacts	111,940	113,900	120,220	122,450	3.0%	1.9%	2.8%

Annex G

Executive Agencies of the Department of Health

NHS Estates Agency

1 The Department's former Estates Directorate was launched as an Executive Agency on 1 April 1991. The Agency's task is to support Ministers, the NHS Executive and the NHS in the management of its £24 billion estate and annual capital investment programme of over £1.2 billion. It employs about 130 staff with a total annual expenditure of about £8.5 million.

2 The Agency's main objectives are to encourage effective, efficient and economical management of the property used for healthcare and to promote excellence of design, with value for money, in new buildings. As property advisers and consultants to the healthcare industry, the Agency provides advice to Government on health policy. It also offers professional consultancy services to all branches of the NHS, the private sector, and overseas clients.

3 Key tasks and targets 1995-96

- Enter into new agreements and work closely with Regional Directors, as influential new customers. (By 30/6/95).
- Develop an effective contracting process with individual NHS Trusts and investigate with them the possible establishment of a single representative body. (By 31/12/95).
- Demonstrate an increasing degree of customer satisfaction and demand year on year through existing contract renewals, positive contract reviews and customer surveys. (Ongoing).
- Provide services which enable the achievement of both Ministers' key estate and Agency Framework objectives. (Ongoing).
- Agree core estate policy support services to be provided indefinitely by DOH personnel. (By 31/3/96).
- Identify present skills and future needs for estate support to Regional Offices and establish suitable management structure. (By 31/3/96)
- Create and staff discrete management structure and support systems to provide and maintain effective delivery of core functions. (By 31/3/96).
- Restructure all remaining business area activities, personnel and support systems to better develop non-core trading functions prior to privatisation. (By 31/3/96).
- Whilst increasing trading activity turnover, deliver the agreed net running costs limit of zero. (By 31/3/96).
- Complete untying process to NHS customers during the year. (By 31/3/96).
- Introduce a cost weighted activity index covering 38 per cent* of the Agency's business. (Within 3 months of the agreed core activity announcement).

* Precise figure dependent upon the core activity announcement.

The 1994-95 Annual Report and Accounts were published in July 1995 and contain more information on the Agency's activities. Copies of this document are available from NHS Estates, Trevelyan Square, 1 Boar Lane, Leeds LS1 6AE. Tel: 0113 254 7000

NHS Pensions Agency

1 The NHS Pensions Agency was launched in November 1992 and is responsible for the administration of the NHS Occupational Pensions Scheme for England and Wales. The Scheme is seen by Ministers as an integral part of the Human Resources Strategy in the NHS. The Agency's framework document requires:

- a timely, accurate and helpful service to its 1.4 million customers;
- prompt and accurate collection of all monies due to the scheme from some 800 NHS employers;
- value for money from all aspects of its operations;
- provision of advice to interested parties about the Scheme; and
- involvement in NHS and Government pensions policy.

2 The Agency handles some 250,000 pensions transactions in a year, updates over 750,000 members records; has preserved some 250,000 leavers pensions for payment at age 60; and contracts the payment of its 450,000 monthly pensions.

3 The Agency has continued with its published programme of reducing running costs while improving quality of services to customers. It has done so to date within the inherited systems and organisation but it plans, from 1996-97, to operate from a radically reengineered business structure; new IT systems; and a considerably reduced, but more professional skills base. These were delivered throughout 1995-96, through programmes for strategic market testing; a commercial IT partnership; and through Investors in People, formal accreditation of which was conferred by Lancashire Area West Training and Enterprise Council (LAWTEC) in March 1995. These programmes project running cost reductions in a full year (from 1997-98) of some £6 million and a potential efficiency gain of up to 40 per cent in output unit costs (work clearance/all costs) over the launch position. By mid 1997 the Agency has contracted to shed more than 250 posts over the manning position in November 1992, will have placed 65 per cent of its £20 million running costs to completion of some kind; and will have completed the installation of a new computer system integrating members' and pensioner records.

4 A competitive, quality service cannot be provided by the Agency without the full cooperation of the NHS employees. To facilitate this in 1995 the Agency completely reshaped itself into client centres designed to deal with each employer individually. Business Agreements with individual employers were introduced for 1995-96.

5 In line with the principles of the Citizens Charter, the Agency sent out over 9,200 copies of the Member's Charter Commitment to Service in 1994-95. This sets out the levels of service members can expect in key target areas. Responses from members were sought in a separate questionnaire and these revealed a 95 per cent rate of customer satisfaction.

6 The Agency also introduced a package of Major Scheme Changes in conjunction with consolidation of operating Regulations. These changes required the issue of 1.2 million publicity packs to members and seminars and guides for employers. Training on pension administration was made available to employers through an external agency. The main Scheme Changes provide for voluntary early retirement from age 50, a formal definition of retirement with a significant break in service and for membership of the Scheme to cease on retirement with no abatement of benefits on re-employment. The package thereby allows for flexible retirement between the ages of 50 and 70. Death benefits were improved and some outdated provisions removed for new members.

Copies of the Annual Report and Accounts are available from NHS Pensions Agency, Hesketh House, 200-220 Broadway, Fleetwood, Lancs FY7 8LG. Tel: 0253774774. This includes an outline of the Agency's forward plans. The Agency produces Business and Corporate Plans which are also available direct from the Agency.

Medical Devices Agency

1 The Medical Devices Agency was launched in September 1994. It safeguards public health by ensuring that medical devices and equipment for sale or use in the United Kingdom meet appropriate standards of safety, quality and performance. It has some 150 staff, mainly in London but with some in Blackpool and Surrey, and running costs of approximately £11 million.

2 The Agency audits the quality assurance systems of medical device manufacturers; investigates adverse incidents with devices in use and issues safety warnings; manages an evaluation programme; helps set national and international safety and performance Standards; and offers advice on medical device safety to a wide range of customers. It leads for the UK in negotiating and implementing a series of European Directives. As the Competent Authority for the UK, it enforces the Directives, appoints and monitors Notified Bodies who ensure that manufacturers comply with certain requirements of the Directives, and assesses applications from manufacturers for clinical investigations.

Key Tasks and Targets 1994-95

3 The Agency met most of its key targets for 1994-95. It audited 230 manufacturing sites, investigated nearly 4,000 adverse incidents, and published 160 evaluation reports. It also published a booklet Doing No Harm, to explain to nurses, midwives and health visitors how the MDA can help them. It transposed the provisions of the Medical Devices Directive into UK legislation and promoted the Agency's role in incidents involving medical devices to Trust hospitals, manufacturers, coroners and the police. Further details can be found in the Agency's Annual Report and Accounts for 1994-95.

Key Targets 1995-96

4 The Agency's key targets for the current year are to:

- establish users' level of satisfaction with existing evaluation services and reports; identify potential new customers and products and ways of improving existing products; and agree a Marketing Plan;
- construct unit cost data by March 1996 as the basis for developing an indicator of the Agency's overall efficiency;
- put in place an efficiency programme which enables the running cost to be reduced by 3 per cent for the same levels of activity;
- improve value for money provided by Evaluation Centres by reviewing their contracts and extending the scope of their services;
- remain within running costs and other cash limits;
- recover 65 per cent of the costs of the Manufacturer's Registration Scheme;
- untie at least 20 per cent of the evaluation programme funds for the NHS;
- manage the relocation of the Agency, maintaining staff morale, avoiding disruption to business, improving the use of office space and improving the handling of customer communications; and
- introduce new procedures to improve analysis and investigation of adverse incidents, selecting some for focused investigation.

Forward Plans

5 The Agency has published its Corporate Plan for 1995-2000. This highlights three of the Agency's services where there are likely to be particular changes and developments within the next five years:

- to continue to apply European regulations sensitively, striking a balance between placing unnecessary burdens on the industry and achieving effective protection of patients and users of medical devices;

- to achieve a smooth transition from the voluntary Manufacturer Registration Scheme to statutory controls under the European regulations, in terms of service and protection for purchasers of medical devices; and

- to move the evaluation programme from top-sliced funding to direct customer sales, making the programme ever more responsive to customer needs whilst giving best value for money.

Any of the documents mentioned here can be obtained from Malcolm Ridgway on 0171 972 8133."

Medicines Control Agency

1 The Medicines Control Agency (MCA) was launched as an executive agency on 11 July 1991 and became a trading fund on 1 April 1993. The MCA is the UK regulatory authority charged with protecting public health through the control of human medicines. It carries out this task through a system of licensing, inspection, monitoring and enforcement and operates under the Medicines Act and European legislation. The Agency employs 400 staff and has an annual turnover of about £20 million derived from fees charged to the pharmaceutical industry. These fees wholly cover the Agency's costs.

Key Tasks and Targets 1994-95

2 The Agency achieved all its high level targets relating to public health for 199495 and achieved most of its other targets, in many instances exceeded them, whilst achieving an efficiency saving of over 2 per cent. All European applications were processed within EC timetables and there was no backlog in abridged licensing.

Key Tasks and Targets 1995-96

3 The MCA is required to meet a series of key tasks and targets, details of which are contained in its Annual Report. They include enhanced monitoring of new medicines to ensure their safety and quality, and targets for the assessment of licence applications within tight timetables and to develop agreements in Europe for greater public access to information.

4 Financial targets require the Agency to operate within budget (which incorporates a 2 per cent efficiency saving) and within an external financing limit of £5.4 million for 1995-96. The Agency has also to achieve a return of 6 per cent.

Forward Plans

5 The Agency has been closely involved in the new European systems for medicines control which began in January 1995. Its Corporate Plan addresses the changes in organisation and procedures which will be needed in order to meet the challenges of the new systems and the financial consequence of the European procedures.

6 The Agency has continued to invest in state of the art information technology systems. The Agency's new computer database, PLUS (Product Licence User System) became fully operational in February 1995. The AEGIS network gave more companies access to adverse drug reaction data and the MEDDRA, the Agency's medical dictionary for drug regulatory affairs, was accepted as the basis for a new international regulatory medical terminology.

7 The Agency's key targets for 1996-97 will be published in its Business Plan.

Reports and Accounts

The MCA's Annual Report and Accounts for 199495 and the Business Plan for 199596 may be obtained from the office of the Chief Executive. The address is Room 1628, Market Towers, 1 Nine Elms Lane, London SW8 5NQ. Tel: 0171 273 3000.

Youth Treatment Service

1 The Youth Treatment Service (YTS) was established as an Executive Unit of the Department of Health on 1 April 1992. The YTS employs around 200 staff and its total annual expenditure is around £8 million. The Service's main objective is to help some of the most difficult and disturbed young people in the country, including young offenders convicted of some of the most serious crimes, whose needs are unlikely to be met readily elsewhere.

2 The YTS originally managed two secure centres at St Charles in Brentwood Essex and at Glenthorne in Birmingham with up to 60 secure places. The St Charles Centre was closed during the course of the year because the deterioration in the standard of the buildings and problems of management and control made it no longer a safe environment for the children and young people detained there.The number of secure places at Glenthorne is being expanded to 40.

3 A full accruals accounting system was introduced from 1 April 1994 and from that date the accounts are subject to audit by the National Audit Office. The YTS recovers the cost of young people placed in its care from local authorities and the Home Office.

4 The YTS aims to provide high quality care for the young people in its care, while ensuring value for money.

Forward Plans and Future Targets

5 Forward plans, including key targets for 1996-7, will be considered by Ministers early in 1996.

Annex H

Central Health and Miscellaneous Services / Non Departmental Public Bodies

VOLUNTARY SECTOR SUPPORT: The aim of the £50 million annual funding by the Department of Health of the voluntary sector is to support and promote Ministers' policies, priorities and objectives across the entire spectrum of HPSS activity. Funding goes primarily to national voluntary organisations and is not designed to supplement or replace statutory funding for local voluntary groups. Voluntary sector funding is an effective means of developing models of good practice in particular areas of provision, encouraging voluntary sector involvement in the delivery of health and personal social services, and reducing dependence on public sector funding of these services. The largest of the current schemes with a provision of £20.3 million in 1995-96 is the Section 64 General Scheme, but there are also some time-limited schemes which have been launched to promote specific Ministerial initiatives. Each scheme has its own set of objectives and output, and performance is measured against these. Grants awarded under the Section 64 General Scheme are monitored and reviewed in accordance with guidance agreed with H M Treasury. Every year the Treasury selects for review six voluntary organisations, grant aided under the Scheme, to satisfy itself that the agreed criteria have been properly applied.

CENTRAL COUNCIL FOR EDUCATION AND TRAINING IN SOCIAL WORK: CCETSW, which employs about 240 staff, has a statutory remit to promote and regulate training for social services staff at all levels and across all sectors. Its main functions are to validate social work qualifying programmes, post qualifying programmes, to approve assessment centres and the arrangements for the delivery of vocational training and to administer bursaries for post-graduate social work students. CCETSW receives a grant of £29.9 million of which £14.2 million is used for student bursaries and a further £8.3 million is used as disbursements to training providers. The qualifying student intake is about 5,500 a year and in 1995-96 about 17,000 are expected to be registered for vocational qualifications.

HEALTH EDUCATION AUTHORITY: The HEA has a statutory remit to provide information and advice about health directly to the public; support health professionals and others who provide health education to the public; and advise the Secretary of State on matters relating to health education. It designs and manages health education programmes, commissions materials, gives policy advice, and commissions research to advance the scientific basis of health education. Three quarters of its revenues are contracted out to a mix of suppliers including major advertising agencies and small specialist teams.

In December 1994, Ministers announced a major change in the way in which the HEA will be funded from April 1996. Income will derive from specific contracts with the Department of Health and other funders. The Department's budget for health promotion will be opened up to competition from other suppliers through a process of competitive tendering. 1995-96 saw the start of the tendering process for a wide range of work, and the process will continue in 1996-97 as existing HEA projects come to an end. In 1996-97 the Department expects to send £0.3 million on the HEA.

NATIONAL RADIOLOGICAL PROTECTION BOARD: The Board has a statutory duty to advance through research the acquisition of knowledge about the protection of mankind from radiation hazards and to provide information and advice to government departments and others, accordingly. It also provides related contract support and technical services for which it levies charges. The Board's annual budget is approximately £14 million, of which DH and SOHHD provide £6 million, and it employs about 320 staff. The Department of Health is expected to spend £6.4 million on the NRPB in 1996-97.

The Board has published formal advice on a number of matters relevant to public health protection against ionising and non-ionising radiation such as the effects of visual display units, the risk of cancer from electromagnetic fields, the delineation of radon affected areas and the standards of protection in dental radiography. Research projects included epidemiological studies of cancer among various groups exposed to radiation, consequences and countermeasures in the event of nuclear accidents, doses arising from the disposal of radioactive waste and biological studies of ultraviolet radiation in support of the "Health of the Nation" campaign to prevent skin cancer.

The Board continued to consolidate its presence on various international commissions and in particular made a considerable contribution to the radiation protection programme of the European Commission under the Euratom Treaty.

PUBLIC HEALTH LABORATORY SERVICE: The primary function of the PHLS is to improve the health of the population through the diagnosis, prevention and control of infections and communicable diseases in England and Wales. It operates through a network of area and regional laboratories located in hospitals together with its Central Public Health Laboratory, Communicable Disease Surveillance Centre and PHLS Headquarters sited at Colindale, London.

The Board has a turnover of about £100 million including £57 million funded by DH and income of £38 million from contracts for the provision of services to the NHS. It employs about 3,500 staff who examined almost ten million microbiological specimens during the year.

The PHLS enhanced its surveillance of HIV and sexually transmitted diseases and continued to provide advice and information to DH to assist in policy formulation and operational issues relating to communicable disease control.

To develop the control of water and food borne diseases two additional surveillance groups were established to co-ordinate investigations and surveys of shellfish and dairy products. The PHLS is now the largest tester of food specimens (over 140,000 a year) in the UK.

NATIONAL BIOLOGICAL STANDARDS BOARD: The NBSB has a statutory duty to maintain the high standards of quality and reliability of biological substances used in medicine, such as vaccines, hormones, blood products and immunologicals; to develop and make available biological standards and to conduct associated research and development. The Board operates through its management of the National Institute for Biological Standards and Control (NIBSC) which has some 260 staff and now tests around 2,000 batches of biological medicines per year. The cost to DH in 1996-97 will be £9.1 million.

During 1994-95 NIBSC became the first of the eight European Control Testing Laboratories to achieve international accreditation to quality standard EN45001. European testing of all batches of biological medicines by NIBSC was completed within target deadlines during a ten month period and the total number of batches tested increased by eight per cent on the equivalent period in 1993-94.

NIBSC continued its range of work for DH and various agencies, particularly its activities to provide reference standards for the Blood Transfusion Service to help ensure the safety of blood at the point of donation.

MICROBIOLOGICAL RESEARCH AUTHORITY: The MRA was established as a special health authority on 1 April 1994 to manage the Centre for Applied Microbiology and Research (CAMR) which had previously formed part of the PHLS. The Authority is required to contribute to the health of the UK population by conducting research on specified microbiological hazards with a view to the development and production of effective diagnostic, prophylactic and therapeutic products.

The MRA has an annual revenue budget of approximately £16 million - about two thirds earned through income mainly from commercial research and production contracts and about one third under contract with DH (DH will contribute some £5.6 million in 1996-97). It employs some 430 staff.

Existing manufacturing includes specific vaccines and a number of enzyme products some of which are employed in cancer treatments. Since 1 April 1994 the MRA Board has created a new Business Development Division to market CAMR more aggressively and has sought to encourage a more commercial culture throughout the Centre. Greater emphasis has been placed on CAMR's scientific and organisational strengths to focus them for business purposes on providing products and services by innovative applied microbiology to meet healthcare and environmental needs worldwide on a commercial basis.

DENTAL PRACTICE BOARD: The DPB's role is to check and price some 38 million claims for remuneration; make the resultant payments (of some £73 million per month) to 22,000 dentists' contracts; maintain the registration of over 30 million patients; monitor the dentists' activities and take action where necessary. The administration cost in 1996-97 is expected to be £20.5 million. The Board's performance is regularly reviewed with the Department. The Board plans to continue to reduce unit costs, year on year, over a 5 year cycle. Investment in an Electronic Data Interchange programme now means that some 21 per cent (6.5 million) of the claims are received by computer. Market testing to the value of some £5 million is underway.

PRESCRIPTION PRICING AUTHORITY: The Authority calculates the amounts due for supplying drugs and appliances prescribed under the NHS. Over 480 million prescriptions are issued each year. The Authority also produces information about prescribing trends and drug usage, monthly reports showing actual spending on drugs set against predetermined amounts under the Indicative Prescribing Scheme or the GP Fundholding Scheme and the monthly Drug Tariff. Under the NHS Low Income Scheme, the PPA assesses some 1.2 million claims for the remission of NHS charges in respect of prescription, dental and other chargeable services. The Authority's costs for 1996-97 are expected to be £47.5 million. Various performance targets have been set for the Authority's work and there have been steady decreases in the cost per priced prescription from 6.06p in 1992 to 5.60p in 1994 together with increases in the numbers of prescriptions priced per staff member from 257,000 in 1992 to 265,000 in 1994. Savings have been made in the operation of the Low Income Scheme and more are expected as the Authority takes on more directly recruited staff. Further efficiency savings are being pursued through a rolling programme of market testing. The first contracts, for the prescription pricing service, covering 75 per cent of the PPA's staff, are due to take effect from April 1995.

SPECIAL HOSPITALS SERVICE AUTHORITY: The Special Hospitals Service Authority (SHSA) is to be abolished. The necessary amending regulations will be laid before Parliament and are intended to come into effect on 1 April 1996. Three new special health authorities will be established to manage the Ashworth, Broadmoor and Rampton hospitals. The new authorities will be responsible for providing care, treatment and rehabilitation for about 1600 patients under conditions of special security. Their wider responsibilities will include promoting research into forensic psychiatry and developing links with other NHS psychiatric services.

The hospitals will remain committed to maintaining and developing the important advances in patient care which have taken place under the management of the SHSA - for example, the introduction of twenty-four hour nursing care which is on target to be extended to all wards by the end of March 1996.

The funding and commissioning of high security services will be the responsibility of the NHS Executive, advised by a new High Security Psychiatric Services Commissioning Board, which includes members drawn from the NHS and other key agencies. The Board will be chaired by Mrs Anne-Marie Nelson, outgoing Chairman of the SHSA. These new arrangements will bring high security services more closely in line with the rest of the NHS by separating responsibility for commissioning and provision of services, giving more responsibility to local management of the three hospitals and involving NHS purchasers in the commissioning process.

FAMILY HEALTH SERVICES APPEAL AUTHORITY: The Family Health Services Appeal Authority is a special health authority established on 1 April 1995. Its function is to determine appeals against decisions taken by family health services authorities under the provisions of the NHS (Pharmaceutical) Regulations, the "Statement of Fees and Allowances Payable to General Medical Practitioners" and the NHS (Service Committees & Tribunal) Regulations. The Authority employs 34 people. The authority is funded through a DH central budget which is set at £1.352 million for 1996/97.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING: The functions of the Board (set out in detail at section 6 of the Nurses, Midwives and Health Visitors Act 1979) are to approve training provision; ensure courses meet the required standard; hold examinations; promote improved training methods; and provide information to the public about careers in the professions of nursing, midwifery and health visiting in England.

The ENB has a staffing level of 141 whole time equivalent posts and as a statutory body is funded annually from the Department HCHS central budgets. The budget for 1996-97 is £6.7 million

NATIONAL BLOOD AUTHORITY: The National Blood Authority (NBA), a Special Health Authority, is responsible for the management of the National Blood Service in England, including the collection of blood from voluntary donors, its processing, testing and supply to hospitals. It is also responsible for the International Blood Group Reference Laboratory (IBGRL), and the Bio Products Laboratory (BPL) which makes therapeutic products from blood plasma and makes and issues diagnostic materials. The national blood service and IBGRL and BPL together have some 5,000 staff (about 4,500 whole time equivalent posts). Running costs totalling some £200 million are largely recouped through blood handling charges to hospitals, and through sales of BPL products. Ministers announced in November 1995 that they had accepted NBA plans for the future organisation of the blood service. After initial costs, savings of £10 million a year from reduced operating costs are expected to become available in about 3 years time for improved patient care elsewhere in the NHS.

THE UNITED KINGDOM TRANSPLANT SUPPORT SERVICE AUTHORITY: UKTSSA is a Special Health Authority of the NHS which was established on 1 April 1991. The Authority supports organ transplantation throughout the UK and Eire. Its main objective is to facilitate the effective and equitable distribution of human organs for transplantation. The Department of Health funds the UKTSSA through a centrally held budget in Vote 1. Other UK countries contribute on the basis of agreed proportions. The centrally held revenue budget for 1996-97 is £4.1 million. In addition, the UKTSSA will be allocated £212,000 to operate and maintain the NHS Organ Donor Register which is a computerised record of people who have registered their wish to be an organ donor.

The staffing establishment at the end of 1995-96 is planned to be 102 WTE. The UKTSSA's management arrangements were reviewed in 1993 and Ministers accepted the reviews recommendation that the UKTSSA should be retained as a Special Health Authority for at least a further 5 years.

Annex I

Deregulation

Strategy for Reducing Burdens

1. The Department is fully committed to the deregulation initiative and attaches great importance to reducing regulatory, administrative and enforcement burdens on business, the voluntary sector and local government. Because a certain amount of regulation is essential to ensure public safety and protect human health, one of the Department's main aims is to achieve better and more effective regulation.

Achievements in 1995-96

2. The Department of Health is not a major regulatory department but 1995-96 saw major deregulatory measures, particularly in the fields of food hygiene and human medicines

- The Food Safety (Temperature Control) Regulations, which came into force on 15 September 1995, introduced a system based on a single maximum storage requirement of 8°C. Compliance cost savings to business are estimated at £41 million per annum

- The Food Safety (General Food Hygiene) Regulations, which replaced 11 sets of regulations with a single piece of simpler, more risk based legislation also came into force on 15 September 1995

- The Medicines Act (Amendment) Regulations Order, which came into force on 29 September, removed the need for data sheets, and

- The Medicines (Exemption from Licences) (Clinical Trials) Order and The Medicines (Exemption from Licences and Certificates) (Clinical Trials) Order, which came into force on 8 December, reduced the number of changes which need to be notified to the Medicines Control Agency (the licensing authority) by an estimated 30 per cent per year.

3. To date the Department has :

- Amended or repealed 46 (out of a total of 75) regulations targeted for reform; and

- Implemented 9 of the 11 Business Task Force proposals accepted by the Department and 6 of the Charities and Voluntary Organisations Task Force proposals for reform

4. To reduce burdens arising from primary legislation - on placements within residential care homes and in the provision of day care services for children - 2 proposals have been put forward for use of the 1994 Deregulation Act order-making power. A draft order to exempt supervised activities from the requirement to register with local authorities - and to relax the registration requirements for holiday playschemes for children - will be laid before the Parliamentary Deregulation Committees on 18 March

5. Four proposals for application of enforcement powers in the Deregulation and Contracting Out Act 1994 have also been put forward. These will improve the fairness, transparency and consistency of existing enforcement procedures.

6. Reviews of business licences and administrative forms (sent to business and the voluntary sector) are also in hand . To date :

- 3 business licences (out of a total of 18) have been simplified and 15 are under review.
- 69 administrative forms (out of a total of 144) have been abolished and 27 have been simplified.

Plans for 1996-97

7. In addition to completion of the review of business licences by June 1997, work plans for 1996-97 include:

- consultation (and possible implementation) of recommendations stemming from the review of the regulation and inspection of social services
- inputting of UK review recommendations to the European Commission's own review of the EC Food Hygiene Directive and issuing proposals for updated Food Safety Act Codes of Practice to help local authorities;
- consultation on a number of legislative proposals to improve or modernise existing legislation (eg. skin piercing and communicable disease control)
- repeal or amendment of 24 regulations and review of 37 administrative forms
- possible negotiation of the proposed In-Vitro Diagnostic Medical Devices Directive, and
- in the field of human medicines, simplification of pharmacy records and abolition of the need for wholesale dealers and manufacturers to renew licences after 5 years.

Annex J

Long term capital projects - Details of capital projects costing over £15,000,000 and reconciliation with Estimate

Project/Scheme [2]	Year of start/ original estimate of year of completion	Current estimate of year of [3] completion	Original estimate of [4] expenditure	£000 at 1996-97 prices [1] Total	Spent in past years	Estimate provision for 1996-97	To be spent in future years
NORTHERN & YORKSHIRE REGION							
Leeds General Infirmary Redevelopment	1994-95/1996-97	1996-97	79,612	80,025	54,765	17,317	7,943
Hull Royal Infirmary Redevelopment	1996-97/1999-00	1990-00	31,222	31,222	1,740	6,320	23,162
Harrogate Rationalisation of Acute Services	1993-94/1998-99	1998-99	34,804	34,805	17,486	7,057	10,262
Cumberland Infirmary Redevelopment	1995-96/1997-98	1997-98	38,495	38,495	9,260	22,188	7,047
City Hospitals Birmingham-New DGH	1996-97/1998-99	1998-99	15,973	15,972		2,862	13,110
Pinderfields New Wing & Stanfield	1997-98/2000-01	2000-01	34,613	34,613		976	33,637
Bishop Auckland Hospital-PH3 Redevelopment	1996-97/2001-02	2001-02	29,739	29,739		3,504	26,235
Bradford Phase II- Option II	1996-97/1999-00	1999-00	66,794	66,794		9,289	57,505
North Durham-Redevelopment of Dryburn Hospital	1996-97/2002-03	2002-03	106,388	106,388	3,752	3,891	98,745
South Tees Acute Hospital- Single Site	1996-97/1999-00	1999-00	77,724	77,724	2,015	6,756	68,953
NORTH THAMES REGION							
Barnet General Hospital Redevelopment-Phase 1A	1994-95/1996-97	1996-97	30,789	30,202	20,357	7,514	2,331
Mid Essex Orthopaedics, Plastics & Burns	1995-96/1997-98	1997-98	29,712	29,712	2,772	16,856	10,084
SOUTH THAMES REGION							
Lewisham Phase 2	1995-96/1996-97	1996-97	40,846	40,847	20,844	15,423	4,580
Medway DGH Development	1995-96/1998-99	1998-99	57,119	57,119	4,304	18,716	34,099
Worthing Acute & Elderly Services-Main Contract	1993-94/1996-97	1996-97	49,065	46,179	27,183	12,765	6,231
Royal Sussex County Hospital Development	1994-95/1997-98	1997-98	56,067	56,068	31,564	17,777	6,727
Queen Elizabeth Military Hospital Woolwich	1995-96/1997-98	1997-98	30,694	30,693	8,772	17,587	4,334
Rationalisation of Services- W.Sussex/Chichester	1995-96/1998-99	1998-99	12,734	12,734	207	4,475	8,052
ANGLIA & OXFORD REGION							
Stoke Mandeville-Redevelopment Option 2 Phase I	1995-96/1998-99	1998-99	32,698	32,697	2,398	9,583	20,716
SOUTH & WEST REGION							
West Dorset DGH Phase 2	1993-94/1998-99	1998-99	43,495	42,169	22,175	9,822	10,172
Royal United Hospital Bath- Redevelopment	1996-97/1999-00	1999-00	33,371	33,371		4,309	29,062
Gloucestershire Royal Hospital-Site Redevelopment	1995-96/1998-99	1998-99	23,024	23,024	3,169	7,415	12,440
United Bristol Hospital For Sick Children	1996-97/1998-99	1998-99	22,600	22,600		2,885	19,715
WEST MIDLANDS REGION							
North Staffs Combined Acute & Community MH	1996-97/1997-98	1997-98	22,231	22,232	291	12,481	9,460
Hereford Hospital-Rationalisation At County Hospital	1996-96/1998-99	1998-99	38,134	38,133	1,159	11,491	25,483
TRENT REGION							
Derby City Hospital Paediatrics	1994-95/1996-97	1996-97	15,226	16,066	14,414	1,267	385
Northern General Phase 3A Cardiothoracic	1995-96/1996-97	1996-97	20,598	26,933	12,523	10,538	3,872
Leicester RI-Clinical Oncology & Haematology	1995-96/1997-98	1997-98	15,547	15,546	2,768	8,451	4,327
NORTH WEST REGION [6]							
Warrington Community -Reprovision of Winnick Hospital	1996-97/1998-99	1998-99	16,981	16,981	350	12,060	4,571
Walton Neuroscience NHS Trust-Hospital Relocation	1996-97/1998-99	1998-99	17,700	17,700	575	10,000	7,125
Rochdale Healthcare NHS Trust - Rochdale Infirmary Development	1996-97/1998-99	1998-99	16,586	16,586	300	2,000	14,286
TOTAL			1,140,581	1,143,369	265,143	293,575	584,651

Notes:

(1) The original estimates of expenditure and the current estimates of expenditure on the main contract and on fees and equipment have been brought to 1996-97 prices using the GDP deflator. The expected expenditure on the main contracts has been revalued from tender base year prices using the APSAB/FORVOP index published by DOE (Quarterly Building Cost and Price Indices), which reimburses a contractor for price fluctuations occurring between the base date for the tender and the month in which is carried out on site.

(2) Included if current estimate costs together with other sources of funds e.g. University Funding Council are £15,000,000 or more

(3) The dates shown for year of start/completion refer to the main contracts or where this is not available to a provisional estimate of contract start/completion date. Only schemes on site during 1996-97 are itemised in the first part of the table. Schemes which will reach practical completion before the start of 1996-97 or which are due to start on site after 1996-97 are not shown there, though there may be expenditure on the latter scheme in the form of fees, equipment costs, enabling works, etc.

(4) Based on accepted tender price, or if not available, budget cost reconciled to expected tender date. Covers all project cost including VAT.

(5) Comparing the above projects with previous years' Estimates tables, the trend is:-

	1994-95	1995-96	1996-97
% projects with later current completion date than original	17	0	0
% projects with higher current estimate of expenditure than original	8	34	11

(6) Figures for North West Region are based on Planning Totals produced by the North West Regional Office

Annex K

Information Formerly in the Estimates

From 1996-97 Main Estimates will be presented in a condensed format aligning with cash plan tables (see page 5).

Tables K1 and **K2** detail Appropriations in Aid and contingent liabilities formerly provided through the Estimates. Details of Grants in Aid and Consolidated Fund Extra Receipts can still be found in the Supply Estimates. Other information which is no longer available through the Estimates is contained in the relevant sections of this Report.

Table K1 Appropriations in Aid

based on 1996-97 provision

£'000

Service	Miscellaneous income mainly goods and services.	Revenue from charges.	Sales of assets.	Capital repayments by NHS trusts.	Total
Vote 1					
NHS hospital, community health family health (cash limited), and related services.	2,539	140,000	228,235		370,774
NHS Trusts.				953,000	953,000
General medical services.	0				0
Drugs.	1				1
Dispensing costs.					0
Prescription charge income.		311.538			311,538
General dental services.		424,094			424,094
General ophthalmic services.		40			40
Other family health services.					0
Trust debt remuneration.					0
NHS contributions.	4,466,830				4,466,830
Other.					0
Total	4,466,831	878,211	228,235	953,000	6,526,277
Vote 2					
Departmental administration.	5,569		204		5,773
NHS Estates.	4,917				4,917
NHS Pension Agency.	2				2
Medical Devices Agency.	1,943				1,943
Youth Treatment Service.	6,971				6,971
Non-departmental public bodies and special health authorities.	66,726				66,726
Other services including medical, scientific and technical services, grants voluntary bodies, research and development and information services.	5,409				5,409
Welfare food and European Economic area medical costs.	18,520				18,520
Personal social services.	1,048		255		1,303
Civil defence.			1		1
Central government grants to local authorities.					0
Other.					0
Total	111,105	0	406	0	111,565

Table K2 Contingent liabilities

Vote 1

A statutory contingent liability exists to meet an indemnity to water undertakers to cover any costs, not otherwise covered by insurance, arising from claims alleging harm to health from the operation of fluoridation schemes.

Non-statutory contingent liabilities exist to meet:-

(i) possible liabilities from NHS trusts in respect of contracts entered into between 9 June 1992 and 17 June 1993;

(ii) legal and other costs of medical and nursing staff engaged on clinical trials approved by the National Blood Authority (NBA) of new blood products manufactured by Bio-Products Laboratory (BPL) for the greater benefit of patients. This undertaking also encompasses the cost of any damage claims from patients arising from these clinical trials of new products; and

(iii) an indemnity in similar terms to that described above for water undertakers which supply water that has been fluoridated by other water undertakers.

Vote 2

Non-statutory contingent liabilities exist to meet:-

(i) the cost of any compensation payments arising from trials of a new whooping cough vaccine developed by the Microbiological Research Authority;

(ii) the cost of any compensation payments arising from immunisation of voluntary donors with hepatitis B vaccine. The vaccine is given to increase the blood levels of hepatitis immunoglobulin. Donations of blood taken after this immunisation are then used to manufacture this immunoglobulin which is used for the protection of unvaccinated individuals;

(iii) any claims for compensation payments arising from the immunisation of voluntary donors with specialised immunoglobulin subsequently harvested and used in the treatment of haemolytic diseases of newborn babies;

(iv) the cost of legal or other costs of those other than qualified medical personnel distributing iodine tablets to the general public in the event of a nuclear emergency, in the event of an adverse reaction to those tablets occurring. The distribution of stable iodine tablets to the public would be necessary to prevent the uptake of radioactive iodine. Expert medical advice is that adverse reactions to stable iodine would be most unlikely. It is however necessary to offer an indemnity to those not otherwise indemnified;

(v) any costs arising from an indemnity given to members of the Department of Health's expert advisory committees on Toxicity, Mutagenicity, Carcinogenicity and Medical Aspects of Food against any action or claim against them by reason of or in connection with their duties as members of those committees;

(vi) the cost of any compensation payment due to a negligent act or omission (including costs) arising from an act committed by a lay assessor involved in the Social Services Inspectorate's inspection work, except where a lay assessor is either wilfully negligent or otherwise indemnified. There is an upper limit of £2m on any one claim;

(vii) the Government has paid £42 million to the Mcfarlane trust from which payments are made to haemophiliacs infected with HIV virus following treatment by the NHS with infected blood products. The Department has agreed to pay to the trust any sums required to make payments if the funds already provided prove insufficient;

(viii) an indemnity exists to cover the role of the Independent Complaints Advisor to the Medicines Control Agency and that any pronouncements or decisions gave rise to litigation by the complainant; and

(xi) a contingent liability exists of £500,000 to enable the Family Fund to meet its duties under legislation to its staff in the event of it being wound up.

(vi) the cost of any compensation payment due to a negligent act or omission (including costs) arising from an act committed by a lay assessor involved in the Social Services Inspectorate's inspection work, except where a lay assessor is either wilfully negligent or otherwise indemnified. There is an upper limit of £2m on any one claim;

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(xi) a contingent liability exists of £500,000 to enable the Family Fund to meet its duties under legislation to its staff in the event of it being wound up.

Statistical Notes

Waiting Times (Figures 19 to 20)

Inpatient waiting times information covers patients who are waiting to be admitted to a NHS hospital in England either as a day case or ordinary admission. It does not include: patients admitted as emergency cases; outpatients; patients undergoing a planned programme of treatment eg a series of admissions for chemotherapy; expectant mothers booked for confinement; patients already in hospital but included on other waiting lists; or patients who are temporarily suspended from waiting lists for social reasons or because they are known to be not medically ready for treatment

Inpatient waiting times begin from the date the clinician decided to admit the patient. Patients subsequently offered a date but unable to attend have their waiting times calculated from the most recent date offered. These are known as selfdeferred cases.

Waiting times of patients seen for a first outpatient appointment following a written referral by a GP to a consultant includes patients referred by a GP whether medical or dental attending consultant led outpatient clinics. The waiting time is the interval between the date the GP's referral letter was received by the hospital or community unit and the date when the patient is seen at the outpatient clinic. For patients who refuse an appointment or who fail to attend, whether giving advance warning or not, the interval between the last missed appointment and the date the patient sees the doctor for the first time for outpatient treatment.

Patient's Charter (Figures 16 to 18)

A&E Assessment: the number of patients seen and assessed by a nurse or doctor within five minutes of their arrival at the accident and emergency department(s), as a percentage of the total number arriving.

Cancellation of Operations: the number of patients admitted electively for their operation in the quarter, having suffered a last minute cancellation and waited over a month thereafter for admission, plus the number who, at the end of the quarter, had not yet been admitted and treated, having suffered a last minute cancellation and waited a month thereafter, A last minute cancellation is one made by the provider for non-medical reasons on the day of or after admission. If a patient is transferred between providers, cancellations by previous providers are included.

Waiting in Outpatient Clinics: the number of outpatient attendances where the primary consultation began within 30 minutes of the appointment time, as a percentage of all outpatient attendances.

Practice Charters: the percentages of GP practices which have a charter, as well as the percentage of GP practices which are in the process of developing a charter.

Activity (Table F1)

All estimates are derived from the NHS Executive's quarterly fast track management information system. Figures prior to 1994-5 have been adjusted to take account of definitional changes between pre 1994-5 and 1995-6 to allow direct comparison with 1995-6 figures.

The estimates are on a "purchaser basis" and relate to activity purchased using NHS funds by health authorities and GP fundholders in England (see NHS baseline performance, Appendix A). This includes activity purchased from private hospitals and NHS hospitals outside England, but excludes private patients and patients from outside England treated in English NHS Hospitals. Some activity for the latter may be included through host purchaser services (A&E and Genito Urinary medicine).

The figures in this table are on a different basis to the longer standing series shown in the main body of the baseline performance section, where figures are on a "provider basis", and count all patients treated in NHS hospitals in England, including private patients and NHS patients from outside England.

LIST OF TABLES

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GLOSSARY

Acute Services

Medical and surgical interventions provided in hospitals.

Business Plans

NHS trusts are required to produce an annual business plan against which their performance is monitored. It is an internal management document in which the trust sets out its plans to develop services, its financial projections and its capital building plans.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaption, renewal, replacement or demolition of buildings, items or groups of equipment and vehicles etc. In this Report expenditure on an item is classified as capital if it is in excess of £1,000, unless otherwise stated.

Capital Charges

An element of the financial regime under which health authorities and trusts operate, designed to make the price which a trust charges its purchasers reflect the capital value of that trust's assets.

Cash Limit

A set limit on the amount of money the Government proposes to spend or authorise on certain services or blocks of services during one financial year. Cash limiting enables the Government to maintain firm control over public sector cash expenditure.

Central Health and Miscellaneous Services

These are a wide range of activities funded from the Department of Health's spending programmes whose only common feature is that they receive funding direct from the Department, and not via health authorities. Some of these services are managed directly by Departmental staff, others are run by non-departmental public bodies, or other separate executive organisations.

Community Care

Care, particularly for elderly people, people with learning or physical disabilities or a mental illness, which is provided outside a hospital setting, ie in the community.

Consolidated Fund

The Government's tax revenues and other current receipts are paid into this Fund and the largest part of central government expenditure is financed from it.

Credit Approvals

Central Government permission for individual local authorities to borrow or raise other forms of credit for capital purposes.

Depreciation

The cost calculated in valuing capital assets for replacement and maintenance costs.

District Health Authority (DHA)

The DHA is responsible within the resources available for identifying the health care needs of its resident population and for securing through its contracts with providers a package of hospital and community health services to reflect those needs. The DHA has a responsibility - with the local authority and family health services authority - to ensure satisfactory collaboration and joint planning with other agencies. From 1 April 1996, DHAs and family health services authorities will be replaced by a single health authority at local level with responsibility for implementing national health policy, integrating purchasing across primary and secondary care boundaries.

Directly Managed Unit (DMU)

Directly managed units are hospitals and other units which are managed by a district Health Authority. Internal management arrangements are therefore subject to DHA approval. It is expected that all DMUs will have achieved trust status by April 1996.

Estimates

See "Supply Estimates".

European Economic Area

The European Community countries plus Norway, Iceland and Liechtenstein.

Executive Agencies

Executive agencies are self-contained units established under the "Next Steps" initiative aimed at improved management in Government. They carry out specific executive functions on behalf of the parent Department within an operational framework agreed by Ministers.

External Financing Limits (EFLs)

Trusts, like health authorities, are subject to public expenditure controls on their spending. For trusts this control is the External Financing Limit (EFL)issued to each trust by the NHS Executive. The EFL represents the difference between the resources a trust can generate internally and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference. If the internal resources are more than the capital spend then the money is used to meet any due repayments of debt principal with any excess being invested.

Family Health Services (FHS)

Services provided in the community through doctors in general practice, dentists, pharmacists and opticians, all of whom are independent contractors. Their contracts are set centrally by the Department following consultation with representatives of the relevant professions, and administered locally by FHSAs, Funding of the FHS is demand-led and not subject to in-year cash limits. The exceptions to this are certain reimbursements of practice expenses payable to doctors in general practice (GMS cash limited spending), the costs of FHSA administration, and expenditure by GP fundholders on drugs. Funding for these items is included in (cash limited) HCHS funds.

Family Health Services Authorities (FHSA)

FHSAs are responsible for managing the services provided under the NHS by family doctors, dentists, community pharmacists and ophthalmic opticians. FHSAs are at present accountable to the relevant regional health authorities and work in close collaboration with DHAs. From 1 April 1996, FHSAs and district health authorities will be replaced by a single health authority at local level with responsibility for implementing national health policy, integrating purchasing across primary and secondary care boundaries.

General Medical Services (GMS)

Personal medical services provided by general medical practitioners: for example, giving appropriate health promotion advice; offering consultations and physical examinations: offering appropriate examinations and immunisations; etc.

GP Fundholders

Family doctors (GPs) whose practices have chosen to accept an agreed budget for part of their practice activity and to manage that budget themselves. The budget covers practice staff, hospital referrals, drug costs, community nursing services, and from April 1995, management costs. This budget is within the cash limited part of HCHS spending.

GDP Deflator

The official movement of pay and prices within the economy that is used for expressing expenditure in constant (real) terms.

Gross/Net

Gross expenditure is the total expenditure on health services, part of which is funded from other income sources, such as charges for services, receipts from land sales and income generation schemes. Net expenditure (gross minus income) is the definition of "public expenditure" most commonly used in this report.

Guardian Ad Litem (GAL)

A guardian ad litem is an independent social worker appointed by the court in care and related proceedings. The guardian's role is to represent the child's interests and to make a recommendation on what outcome is in the best interests of the child.

Hospital and Community Health Services (HCHS)

The main elements of these are the provision of hospital services, and certain community health services, such as district nurses, which are not provided by the FHS. These services are purchased by DHAs and provided by NHS trusts and directly managed units. HCHS provision is cash limited and also includes funding for those elements of FHS spending which are cash limited (GMS cash limited expenditure).

NHS Trust

NHS trusts are hospitals and ambulance services which are managed by their own boards of directors and so are independent of health authority control. NHS trusts are part of the NHS and are operationally independent to provide services based on the requirements of patients as represented by health authorities and GP fundholders.

National Insurance Fund

The statutory fund into which all National Insurance contributions payable by employers, employees and the self-employed are paid, and from which expenditure on most contributory social security benefits is met. The NHS also receives funding from this. A supplement from the Consolidated Fund covers the difference between payments and receipts.

Outturn

Actual expenditure.

Personal Social Services (PSS)

Personal care services for vulnerable people, including those with special needs because of old age or physical or mental disability and children in need of care and protection. Examples are residential care homes for the elderly, home help and home care services, and social workers who provide help and support for a wide range of people.

Primary care

Non acute care which covers community and family health services.

Private Finance Initiative

Describes the use of private finance in NHS capital projects, particularly in relation to the design, construction and operation of buildings and support services. Management of the facility continues to rest with the sponsoring NHS organisation, and care continues to be delivered by NHS doctors and nurses.

Real terms

Figures adjusted for the effect of general inflation as measured by the GDP market price deflator.

Regional Offices

The eight NHS Executive regional offices were established on 1 April 1994. These offices are responsible for developing the purchasing function in the health service and for monitoring the financial performance of NHS Trusts. The regional offices will take on the non-statutory functions of the regional health authorities following their abolition on 1 April 1996.

Revenue

Expenditure other than capital. For example, staff salaries, drug budgets etc.

Secondary care

Care provided in hospitals.

Service Increment for Teaching and Research SIFTR)

The Service Increment for Teaching and Research (SIFTR) is funding intended to compensate hospitals for the extra NHS costs of providing facilities for clinical undergraduate medical and dental education and research. It is currently distributed between regional health authorities in proportion to numbers of clinical undergraduates. From April 1996 funding for NHS spending associated with teaching will be provided for separately from research .

Supply Estimate

A request by the Executive to Parliament for funds required in a financial year to meet most expenditure by Government Departments and certain related bodies. The published Supply Estimates are sub-divided into groups (Classes) which contain provision (usually by a single Department) covering services of a broadly similar nature. A sub-division of a Class in known as a "Vote" and covers a narrower range of services. It is the net provision which is authorised (or "voted") by Parliament.

Special Health Authority

A special health authority is a health authority which provides health services to the whole population of England, not just to a local population. Formerly the London Postgraduate Teaching Hospitals were SHAs but they are now hospital trusts. The remaining SHAs, such as the National Blood Authority, provide clinical or support services to the whole NHS.

Specific Grants

Grants (usually for current expenditure) allocated by central government to local authorities for expenditure on specified services, reflecting ministerial priorities.

Trading Fund

A trading fund provides a financing framework which covers operating costs and receipts, capital expenditure, borrowing and net cash flow. It has powers to meet capital expenditure and working capital requirements, and to establish reserves out of surpluses. Within the framework it can meet outgoings without detailed cashflows passing through Vote accounting arrangements. Trading funds are government departments or accountable units within government departments set up under the Government Trading Funds Act 1973, as amended by the Government Trading Act 1990. The Acts enable the responsible Minister, where he thinks this will lead to improved management efficiency and effectiveness, to set up as a trading fund a body which is performing a statutory and monopoly service whose fees are fixed by or under statute.

Vote

See "Supply Estimate".

Weighted capitation

The principle of weighted capitation is to distribute resources equitably based on the healthcare needs of different resident populations. A national formula is used as the basis for allocating Hospital and Community Health Services (HCHS) revenue to health authorities. The formula uses forecast resident population figures which are then weighted for the cost of care by age group, for relative health which takes the form of two separate needs indices (one for general and acute services and one for psychiatric services), and to take account of the geographical variation in the cost of providing services.

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